STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to obtain a complete and accurate informed consent (process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention to obtain agreement or permission for care, treatment, or services) for the psychotropic medications for three of 28 sampled residents (Residents 8, 86, and 154). * Resident 8's Informed Consent dated 8/17/25, for duloxetine 40 mg po QD (once a day) for depression had no date next to the physician's signature. * Resident 86's Informed Consent dated 7/25/25, for quetiapine 100 mg one tablet by mouth three times a day for psychosis and trazodone (antidepression medication) 100 mg one tablet by mouth every bedtime for inability to sleep had no resident signature on the informed consent. * Resident 154's informed consent (undated) for the buspirone HCl5 mg tablet two times a day had no physician's signature, resident/resident's representative signature, and two licensed nurses' signature. In addition, the informed consent from the DON for the buspirone HCl signed and dated by the physician on 8/11/25, did not have a signature from the resident/resident's representative or two licensed nurses. These failures had the potential to compromise the right of the residents or responsible parties (persons designated to make decisions on behalf of the residents) to be fully informed regarding care and treatment to make health care decisions.Findings: Review of the facility's P&P titled Informed Consent, revised on 11/21, showed it is the policy of the facility to facilitate, when necessary, the obtaining of Informed Consent for medical services that require Informed Consent either by verification of the Informed Consent or by participating in IDT discussions to obtain Informed Consent pursuant to California Health and Safety Code 1418.8 1. Medical record review for Resident 8 was initiated on 8/18/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8 had a BIMS score of 9 (meaning moderate cognitive impairment of mental status). Review of Resident 8's Order Summary Report showed a physician's order dated 8/17/25, to give duloxetine HCl (antidepressant) oral capsule delayed release sprinkle 40 mg give three capsules orally one time a day for depression manifested by verbalization of sadness. Review of Resident 8's MAR for August 2025 showed the resident received duloxetine HCl from 8/17/25 to 8/19/25. Review of Resident 8's Informed Consent dated 8/17/25, showed duloxetine 40 mg po QD (once a day) for depression manifested by verbalization of sadness. The Informed Consent showed no date next to the physician's signature. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/25 at 1031 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 confirmed Resident 8's duloxetine order did not match the order written on the Informed Consent. Furthermore, RN 1 confirmed the resident had been receiving 120 mg of duloxetine once a day. On 8/19/25 at 1342 hours, an interview and concurrent record review was conducted with the DON. The DON confirmed the consent form with the written order needed to match the physician's order. Additionally, the DON acknowledged and confirmed Resident 8 had been receiving 120 mg of duloxetine once a day and the informed consent needed to include the physician's signature with date. 2. Medical record review for Resident 86 was initiated on 8/12/25. Resident 86 was admitted to the facility on [DATE] and readmitted back to the facility on 7/4/25. Review of Resident 86's H&P examination dated 7/10/25 showed the resident had the capacity to understand and make decisions. Review of Resident 86's Order Summary Report for August 2025 showed a physician's order dated 7/15/25, for quetiapine fumarate (antipsychotic medication) one tablet 100 mg three times a day for psychosis manifested by agitation. Review of Resident 86's MAR for July 2025 showed Resident 86 was administered quetiapine fumarate medication starting on 7/16/25. Review of Resident 86's Informed Consent dated 7/25/25, showed quetiapine 100 mg one tablet by mouth three times a day for psychosis and trazodone (antidepression medication) 100 mg one tablet by mouth every bedtime for inability to sleep. Further review of the consent form showed the physician signed on 7/25/25, however there was no resident signature on the informed consent. On 8/15/25 at 1330 hours, an interview and concurrent medical record review for Resident 86 was conducted with LVN 20. LVN 20 verified Resident 86 was on quetiapine medication. LVN 20 verified the consent form was not available in Resident 86's medical records and stated the Medical Records Director might have the copy. LVN 20 stated the informed consents were needed to inform the resident of the medication they were consenting to and be aware of the side effects. On 8/15/25 at 1427 hours, an interview and concurrent medical record review for Resident 86 was conducted with the Medical Records Director. The Medical Records Director verified she had the Informed Consent for Resident 86 in her office. The Medical Records Director verified the physician signed the consent form on 7/25/25; however, there was no documented evidence the resident signed the informed consent. Moreover, the Medical Records Director stated she had not returned the informed consent back in the resident's medical record or gave it to the nursing staff to obtain the resident's signature. On 8/15/25 at 1435 hours, an interview and concurrent medical records review for Resident 86 was conducted with LVN 21. LVN 21 verified above findings and stated Resident 86 was self-responsible and should have signed the consent for the quetiapine medication. On 8/15/25 at 1501 hours, an interview with Resident 86 was conducted in her room. Resident 86 stated she did not recall signing a consent form for the use of the quetiapine medication. When asked if she signs her own documents or has family to sign, Resident 86 stated she signs her own (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documents including the consent forms and did not have her family sign for her. On 8/19/25 at 1008 hours, an interview and concurrent medical records review for Resident 86 was conducted with the DON. The DON verified the above findings. The DON stated the consent form for psychotropic medications should be signed prior to being administered the medication. The DON verified Resident 86 was administered quetiapine medication as of 7/16/25, and stated the consent form needed Resident 86's signature. The DON verified and acknowledged the above findings for Resident 86. 3. Medical record review for Resident 154 was initiated on 8/14/25. Resident 154 was admitted on [DATE]. Review of Resident 154's Order Summary Report showed a physician's order dated 8/9/25, to give buspirone HCl oral tablet 5 mg (antianxiety medication) give one tablet by mouth two times a day for anxiety manifested by restlessness. Review of Resident 154's MAR for August 2025 showed the resident received buspirone HCl from 8/9/25 to 8/15/25. Review of Resident 154's Informed Consent (undated) showed buspirone 5 mg one tab po (by mouth) BID (two times a day) for anxiety. There was no physician's signature, resident/resident's representative signature, and two licensed nurses' signature on Resident 154's Informed Consent. On 8/18/25 at 1042 hours, an interview and concurrent medical record review was conducted with the DON. The DON showed a different consent form signed and dated by the physician on 8/11/25. However, the bottom section did not have a signature from the resident/resident's representative or two licensed nurses. The DON confirmed Resident 154 started buspirone HCl on 8/9/25. On 8/19/25 at 1410 hours, an interview was conducted with the DON. The DON verified the facility attempted to get in contact with Resident 154's representative. However, the facility was not able to get in contact with Resident 154's representative. Furthermore, the DON confirmed the order for the buspirone HCl medication should not be given to the resident until Resident 154's representative could sign or the physician have two medical directors sign in replacement of Resident 154's representative.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for three of 140 residents (Residents 1, 2, and 8). * The facility failed to ensure Resident 1, 2, and 8's call light was within the residents' reach. This failure posed a risk in a delay in providing care to the residents and the potential to negatively impact on the residents' well-being.Findings: 1. Review of the facility's document titled Lesson Plan for Call lights/ Accommodation of Needs (undated) showed the following: - When the residents are placed in a hospital bed, there is one piece of equipment they feel is their lifeline: the call light; - Call lights should be within reach of the resident. Example, if the resident's left arm is not able to move, then place it within reach of the right hand; and - Residents use the call light to communicate with nursing staff. This is one way they can let staff know that they have an unmet need. Some items that they may need assistance with is using the bathroom, getting them a missing supply or item, food or drinks, pain or a physical discomfort, issues that need to be communicated to a loved one, friend, or other medical professional. On 8/13/25 at 1128 hours, Resident 1 was observed lying in bed. Resident 1's call light cord was clipped, and the call light button was hanging on the left side of the mattress. Resident 1 asked for the call light to call the facility staff. Resident 1 stated he wanted the facility staff to apply lotion on him, and he needed the call light button. Resident 1 attempted to reach for the call light on the left side of the bed, but he was unable to reach the call light button. On 8/13/25 at 1131 hours, LVN 16 was summoned to Resident 1's room. An observation for Resident 1 and concurrent interview was conducted with LVN 16. Resident 1 was observed lying in bed, and the call light button was hanging on the left side of the mattress, which was not within Resident 1's reach. LVN 16 verified the above findings. Medical record review for Resident 1 was initiated on 8/12/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had moderate cognitive impairment, and no impairment to the upper and lower extremities. The MDS assessment also showed Resident 1 required a set-up or clean-up assistance for personal hygiene, oral hygiene and eating, a partial or moderate assistance for upper body dressing, and a substantial or maximal assistance for lower body dressing, shower or bathing, and putting on or taking off footwear. On 8/14/25 at 1033 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 1 could verbalize his needs, and he used the call light to ask for help and when he wanted to go to the bathroom. 2. On 8/14/25 at 1052 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 2 could verbalize his needs, and he often used the call light to ask for help and for the treatment nurses. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/25 at 1257 hours, Resident 2 was observed lying in bed. Resident 2's touch call light was observed on the nightstand, on the left side of the bed. Resident 2 stated he wanted his bedside table by the bathroom door because the table was blocking his view of the door. Resident 2 attempted to reach for the call light on the nightstand, but he was unable to reach the touch call light. On 8/15/25 at 1302 hours, RN 4 was summoned to Resident 2's room. An observation for Resident 2 and concurrent interview was conducted with RN 4. Resident 2 was observed lying in bed, and the touch call light was on the nightstand, which was not within Resident 2's reach. RN 4 verified the above findings. Medical record review for Resident 2 was initiated on 8/12/25. Resident 2 was readmitted to the facility on [DATE]. Review of Resident 2's MDS assessment dated [DATE], showed Resident 2 had moderate cognitive impairment, and an impairment on one side of the upper and lower extremities. On 8/19/25 at 1131 hours, an interview and facility document review was conducted with the DSD. The DSD stated the licensed nurses and direct care staff had been provided with an in service to ensure the call lights were within the residents' reach. 3. Medical record review for Resident 8 was initiated on 8/12/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 4/17/25, showed the resident had the capacity to understand and make decisions. Review of Resident 8's plan of care showed a care plan problem dated 5/19/25, addressing the resident's behavior monitoring for getting up out of bed unassisted showed an intervention to keep the call light within reach. On 8/12/25 at 0839 hours, an observation and concurrent interview was conducted with Resident 8, inside the resident's room. Resident 8 was observed lying in bed with the call light on the floor, on the right side of the bed. Resident 8 stated she could not find the call light Resident 8 stated if she tried to reach the call light, which was on the floor at this time and she would fall out of the bed. On 8/12/25 at 0848 hours, an observation and concurrent interview was conducted with LVN 1, inside Resident 8's room. LVN 1 verified Resident 8's call light was on the floor and not within the resident's reach. LVN 1 further stated the call light should be within the reach of the resident to ensure the resident's safety and allowed the resident to communicate with the facility staff when she needed assistance. On 8/14/25 at 1125 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON further stated the call light needed to be within the resident's reach and accessible for the resident at all times, so the resident could call for assistance from the facility staff.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility document review, the facility failed to provide the written Notice of Medicare Non-coverage (NOMNC) form CMS-10123 and the Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) form CMS-10055 for one of three residents reviewed for beneficiary notification (Resident 7). The NOMNC and SNFABN forms are used to inform the residents of their potential financial liability, appeal rights, and protection should they wish to receive care and services that may not be covered by Medicare. This failure had the potential of not allowing Resident 7 and/or their representative to make an informed decision regarding their Medicare services.Findings: Medical record review for Resident 7 was initiated on 8/19/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's MDS assessment dated [DATE], showed Resident 7 had moderately impaired cognitive skills for daily decision making. Review of the facility's Beneficiary Notice- Residents discharged Within Last Six Months showed Resident 7 was discharged from the Medicare Covered Part A stay on 7/18/25, and remained in the facility. Review of Resident 7's SNF Beneficiary Notification Review (undated) showed the facility initiated the discharge from Medicare Part A services even when the resident's benefit days were not exhausted. Review of Resident 7's NOMNC (undated) showed the effective date coverage of Resident 7's skilled nursing service would end on 7/18/25. Under the section for the signature of the patient (resident) or representative, there was no entry. However, the document showed Resident 7's representative was notified via telephone on 7/16/25 and the facility to mail a copy of the letter to the contact person same day as contacted. Review of Resident 7's SNF ABN showed Medicare doesn't pay for everything even some care that you and your health care provider think you need. The Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage or its utilization review committee believes that the care listed below does not meet the Medicare coverage requirement. Beginning 7/19/25, you may have to pay out of pocket for this care if you do not have insurance that may cover those costs. Further review of the document did not show the signature of Resident 7 and/or the resident's representative. Further review of Resident 7's medical records failed to show if Resident 7 and/or the resident's representative were provided with a copy of NOMNC and SNF ABN when Resident 7 was discharged from Medicare Part A services and remained in the facility. On 8/19/25 at 1348 hours, an interview and concurrent facility document review was conducted with the Business Office Manager. The Business Office Manager stated the facility should provide a written notice of NMNOC to the residents when Medicare Part A benefit days were not exhausted and they get discharged from the Medicare Part A services, and a written copy of SNF ABN notice was provided when the residents get discharged from the Medicare Part A services and remained in the facility. The Business Office Manager stated SNF ABN explained the care that cannot be covered under the Medicare and when the resident was financially responsible for the care. The Business Office Manager verified the above findings and stated Resident 7's representative was verbally notified about the NMNOC; however, there was no documentation if the written copy of the NOMNC was provided to Resident 7's representative. In addition, the Business Office Manager was not able to show if a copy of SNF ABN was provided to Resident 7's representative. The Business Office Manger stated the copy of NMNOC and SNF ABN should have been mailed to Resident 7's representative. On 8/19/25 at 1555 hours, the DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure four of six sampled residents (Residents 3, 8, 86, and 154) reviewed for unnecessary medications were free from unnecessary medications. * The facility failed to ensure Resident 3 was monitored for an adverse events such as orthostatic hypotension, and failed to show documented evidence an AIMS assessment was conducted for the use of the Risperdal (antipsychotic medication). * The facility failed to ensure Resident 8's order for lorazepam (antianxiety medication) PRN had a duration for use, failed to show documentation for non-pharmacological interventions for the use of duloxetine (antidepressant medication), and failed to show documentation of the behavior monitoring for the depression. * The facility failed to ensure Resident 86 was monitored for an adverse events such as orthostatic hypotension, and failed to show documented evidence of an AIMS assessment was conducted for the use of the quetiapine fumarate (antipsychotic medication). * The facility failed to ensure Resident 154 had non-pharmacological interventions for restlessness and was monitored for the side-effects of the buspirone (antianxiety medication). These failures had the potential for adverse effects from the psychotropic medications, inaccuracy of monitoring and assessing, and unnecessary use of the psychotropic medications.Findings: According to the National Library of Medicine's DailyMed, Risperdal is indicated for the treatment of schizophrenia, acute manic or mixed episode associated with Bipolar 1 disorder; and for the treatment of irritability associated with autistic disorder, including symptoms of aggression towards others, deliberate self-injuriousness, temper tantrums, and quickly changing moods. The DailyMed showed adverse reactions from the medication may include cerebrovascular reactions including stroke; Neuroleptic Malignant Syndrome-a potentially fatal symptom complex associated with antipsychotic drugs which includes muscle rigidity, altered mental status including delirium, irregular pulse or blood pressure, tachycardia, diaphoresis, and cardia dysrhythmia; Tardive Dyskinesia- a syndrome consisting of potentially irreversible, involuntary muscle movements may develop in residents treated with antipsychotic drugs. Review of the facility's P&P titled Psychotropic Medications revised 11/2021 showed under procedure section, the IDT will check the physician orders for the medication includes the name of the medication, dose, route, times and behavior(s) for which the medication is being administered. The order shall also include monitoring requirements for the behavior(s). The PRN psychotropic medications shall have mandatory stop orders of 14-days and may only be continued or renewed consistent with federal regulations. 1. Medical record review for Resident 154 was initiated on 8/12/25. Resident 154 was admitted to the facility on [DATE]. Review of Resident 154's MAR for August 2025 showed a physician's order dated 8/9/25, for buspirone HCl oral tablet 5 mg, give one tablet by mouth two times a day for anxiety manifested by restlessness. Review of Resident 154's Monitoring Record and MAR for August 2025 failed to show documented evidence of the monitoring for the side-effects of the buspirone medication and documentation of non-pharmacological interventions. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/25 at 1434 hours, an interview for Resident 154 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the facility should monitor the side-effects of the buspirone medication and document non-pharmacological interventions for restlessness. On 8/19/25 at 1410 hours, an interview and concurrent medical record review for Resident 154 was conducted with the DON. The DON acknowledged the monitoring of the side-effects for buspirone medication and documenting of the non-pharmacological interventions should be assessed to ensure the facility was able to monitor the effectiveness of the medication and for the adverse side effects. The DON verified and acknowledged the above findings. 2. Medical record review for Resident 3 was initiated on 8/12/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MAR Report for August 2025 showed a physician's order dated 6/27/25, for Risperdal oral tablet 0.5 mg (risperidone) give one tablet via GT at bedtime for schizophrenia manifested by screaming/ disruptive noises document non-pharmacological interventions as follows: 1. Relaxation 2. Adjust room temp/lighting 3. Reposition 4. Toileting 5. Music/TV 6. Snacks 7. Warm/Cold Compress 8. Other. Additionally, a physician's order dated 8/8/25, showed for hydrocodone-acetaminophen oral tablet 5-325 mg (hydrocodone-acetaminophen) give one tablet via GT every four hours as needed for severe pain (7-10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) document non-pharmacological interventions as follows: 1. Relaxation 2. Adjust room [ROOM NUMBER]. Reposition 4. Toileting 5. Music/TV 6. Snacks 7. Warm/Cold Compress 8. Other. Review of Resident 3's medical record failed to show documented evidence an AIMS (Abnormal Involuntary Movement Scale) assessment was conducted and the resident was monitored for orthostatic hypotension for the use of the Risperdal medication. On 8/15/25 at 1340 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 5. LVN 5 verified there was no monitoring of the side-effect of Risperdal medication and not knowing the side-effects of the medication. On 8/15/25 at 1455 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 3. RN 3 verified the above findings. RN 3 stated she was not aware of the AIMS assessment. On 8/19/25 at 1422 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON verified and acknowledged the above findings for Resident 3. The DON verified the facility was not monitoring for the orthostatic hypotension and conducting an AIMS assessment for the use of the Risperdal medication. 3. Medical record review for Resident 8 was initiated on 8/12/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's MAR Report for August 2025 showed a physician's order dated 8/5/25, for duloxetine HCl oral capsule delayed release sprinkle 40 mg give three capsules orally one time a day for depression. In addition, Resident 8 had a physician's order dated 7/20/25, for lorazepam oral tablet 0.5 mg give one tablet by mouth every six hours as needed for anxiety manifested by agitation document non-pharmacological interventions as follows: 1. Relaxation 2. Adjust room temp/lighting 3. Reposition 4. Toileting 5. Music/TV 6. Snacks 7. Warm/Cold Compress 8. Other. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Furthermore, review of MAR report for August 2025 did not show non-pharmacological interventions documented for the use of the duloxetine medication, monitoring of the behavior for depression, and the PRN lorazepam medication ordered without duration. On 8/19/25 at 0947 hours, an interview and concurrent medical record review for Resident 8 was conducted with LVN 3. LVN 3 verified the findings and was unable to show documentation of non-pharmacological interventions for the use of duloxetine medication. On 8/19/25 at 1031 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the facility should be documenting non-pharmacological interventions for the use of the duloxetine medication. On 8/19/25 at 1350 hours, an interview and concurrent medical record review for Resident 8 was conducted with the DON. The DON verified the above findings. The DON stated if a medication was documented as given on the MAR with only a signature and without a number documented for the non-pharmacological intervention, it meant the non-pharmacological intervention was not done. Additionally, the DON verified the monitoring for the behavior for the verbalization of sadness was not done for the use of the duloxetine medication. The DON confirmed all the PRN psychotropic orders needed to have a duration. 4. According to the National Library of Medicine's DailyMed, quetiapine medication may induce orthostatic hypotension which may lead to falls. The DailyMed also showed a syndrome of potentially irreversible, involuntary muscle moments may develop in residents treated with antipsychotic drugs, including quetiapine medication. Medical record review for Resident 86 was initiated on 8/12/25. Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 86's H&P examination dated 7/10/25, showed the resident had the capacity to understand and make decisions. Review of Resident 86's medical record failed to show documented evidence an AIMS assessment was conducted. Review of Resident 86's Order Summary Report for July and August 2025 failed to show documented evidence of orthostatic hypotension monitoring. Further review of Resident 86's Order Summary Report for August 2025 showed a physician's order dated 7/15/25, for quetiapine fumarate (antipsychotic medication) one tablet 100 mg three times a day for psychosis manifested by agitation. On 8/15/25 at 1330 hours, an interview and concurrent medical record review for Resident 86 was conducted with LVN 20. LVN 20 verified above findings. LVN 20 stated the facility did not monitor the orthostatic hypotension for the residents on the antipsychotic medications and did not assess for AIMS. LVN 20 stated the AIMS and orthostatic hypotension monitoring should be assessed due to the medication, which can cause syncope and lead to a fall risk for the resident. On 8/15/25 at 1348 hours, an interview was conducted with LVN 21. LVN 21 verified the facility did not monitor for the orthostatic hypotension or assess for AIMS. LVN 21 stated the orthostatic (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hypotension should be monitored since the antipsychotic medications can bring down the resident's blood pressure. On 8/19/25 at 1008 hours, an interview and concurrent medical record review for Resident 86 was conducted with the DON. The DON acknowledged the orthostatic hypotension and AIMS should be assessed to ensure the facility was able to monitor the effectiveness of the medication and for adverse side effects. The DON verified and acknowledged the above findings for Resident 86.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop and implement a comprehensive person-centered care plan to reflect the individual care needs for one of 28 final sampled residents (Residents 138). * The facility failed to develop a care plan problem when Resident 138 developed a DTI (Deep Tissue Injury) in the right heel. This failure posed the risk of not providing appropriate, consistent, and individualized care to Resident 138. Findings: Review of the facility's P&P titled Wound Care Guidelines revised 11/2021 under the Documentation section showed care plans are updated accordingly to reflect the current interventions for the wounds and the long-term interventions to prevent further breakdown as appropriate. Medical record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's H&P examination dated 7/14/25, showed Resident 138 had fluctuating capacity but could make needs known. Review of Resident 138's eINTERACT Change in Condition Evaluation dated 8/8/25 at 0615 hours, showed Resident 138 was noted with a DTI in the right heel measuring 4 cm (length) x 4 cm (width) with depth unable to determine. Further review of Resident 138's medical record failed to show documented evidence a care plan was developed for the new DTI noted in the right heel. On 8/14/25 at 1326 hours, an interview and concurrent medical record review for Resident 138 was conducted with LVN 11. LVN 11 verified Resident 138 had a DTI in the right heel. LVN 11 verified Resident 138's plan of care failed to show documented evidence a care plan was developed when the resident developed a DTI in the right heel. LVN 11 stated the care plan should be developed or revised if there was already an existing care plan addressing the skin integrity of the resident. When asked about the facility's process when a resident developed any new skin issue, LVN 11 stated the care plan was important to monitor if the treatment plan was helping to improve the new change in condition identified. On 8/19/25 at 1436 hours, an interview was conducted with the DON. The DON stated the care plan should be initiated as soon as possible for any change in the resident's condition. The DON stated the care plan would have goals and interventions specific to the change in condition and would help determine if the interventions were helping to achieve the set goals for the specific problem related to the resident. The DON was informed and acknowledged the above findings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary care and services for one of one final sampled resident reviewed for ADL care (Resident 102). * The facility failed to ensure Resident 102's long fingernails were trimmed. This failure had the potential for Resident 102 to experience physical discomfort and skin breakdown due to scratching with long fingernails.Findings: Medical record review for Resident 102 was initiated on 8/12/25. Resident 102 was admitted to the facility on [DATE]. Review of Resident 102's H&P examination dated 3/27/25, showed Resident 102 was partially able to make decisions by themselves. Review of Resident 102's MDS assessment dated [DATE], showed Resident 102 had moderate cognitive impairment and had impairment on both sides of the upper extremities. Review of Resident 102's Care Plan showed the following: - dated 3/27/25, showed Resident 102 was dependent on the staff for his physical needs such as transfer and ADL care.- dated 8/3/25, showed a problem addressing potential for skin impairment exhibited by generalized dry and itchy skin. The interventions showed to trim and file fingernails as needed to prevent scratching and further skin breakdown. On 8/12/25 at 0913 hours, and on 8/13/25 at 1235 hours, Resident 102 was observed awake in bed with long fingernails on both hands and was observed scratching both arms with his fingernails. Resident 102's skin on the bilateral arms was observed dry with white flakes. On 8/15/25 at 0848 hours, Resident 102 was observed sleeping in his bed with long fingernails on both of his hands. On 8/15/25 at 1306 hours, an interview with Resident 102 was conducted. When Resident 102 was asked about his long fingernails, Resident 102 stated no one in the facility assisted him to cut his fingernails. On 8/15/25 at 1306 hours, an observation and concurrent interview for Resident 102 was conducted with CNA 6. CNA 6 verified Resident 102's fingernails were long and needed trimming. On 8/15/25 at 1340 hours, an observation and concurrent interview for Resident 102 was conducted with the DON. Resident 102 was observed awake in bed with long fingernails on both hands and was observed scratching both arms with his long fingernails. The DON verified the observation and the above findings. The DON stated she would ask a CNA to trim Resident 102's fingernails. On 8/18/25 at 1737 hours, a telephone interview was conducted with Resident Representative 1. Resident Representative 1 stated Resident 102's fingernails had not been trimmed since the resident had been admitted to the facility on [DATE]. Resident Representative 1 further stated the facility staff did not tell her to trim Resident 102's fingernails. On 8/19/25 at 1446 hours, a follow up interview was conducted with the DON. The DON stated the CNAs in the facility can trim the residents' fingernails if the resident was not diabetic (a person with diabetes). The DON further stated Resident 102 was not diabetic and his finger nailed should have been trimmed especially when Resident 102 had the behavior of scratching the skin.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure three of six final sampled residents (Residents 2, 96, and 138) and one nonsampled resident (Resident 71) reviewed for pressure injury were provided with the necessary care and services. * The facility failed to provide LAL mattress to Resident 138 per the resident's plan of care for wound management and skin maintenance. In addition, the facility failed to ensure Resident 138's LAL mattress setting was accurate to the resident's weight and was not in static mode while the resident was in bed when the LAL mattress was provided. For Resident 138's DTI in the right heel, the facility failed to monitor Resident 138 every shift for 72 hours after the identification of a DTI in the right heel and develop and implement a comprehensive person-centered care plan when the resident developed a DTI in the right heel. The facility failed to ensure the weekly skin assessment was completed for Resident 138 and provided a wound care specialist to Resident 138 after the identification of the DTI in the right heel per facility's protocols. In addition, the facility failed to ensure Resident 138 had heel protectors while in bed per physician's order. * The facility failed to provide bilateral heel suspenders to ensure Resident 2's heels were offloaded per the physician's order. In addition, the facility failed to provide a LAL mattress per Resident 2's care plan for skin maintenance. * The facility failed to ensure Resident 71's LAL mattress setting was accurate to the resident's weight and comfort. * The facility failed to ensure Resident 96's LAL mattress setting was appropriate to the resident's weight. These failures had the potential for the residents not to receive the appropriate care and services to promote skin healing.Findings: 1. Review of the National Pressure Ulcer Advisory Panel's (NPIAP) Guideline titled Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline – The International Guideline 2019, the Skin and Tissue Assessment section showed skin redness is known as erythema. The redness is classified as either blanchable or non-blanchable. Non-blanchable erythema is visible skin redness that persists with the application of pressure. It indicates structural damage to the capillary bed. Initial and ongoing assessment of the skin is necessary to detect early sigs of pressure damage. A visual assessment for erythema is the first component of every skin inspection. Skin redness, in conjunction with tissue edema resulting from capillary occlusion, is a response to pressure, especially over bony prominences. The Heel Pressure Injuries section showed the heel is one of the two most common anatomical sites for pressure injuries. The heel is considered a vulnerable area to pressure damage as compared to other areas of the body due to factors such as heel anatomy, disease burden, comorbid conditions, and the aging process. Due to this vulnerability, it is prudent to regularly assess the heel for pressure damage, especially in individuals who are medically complex. The Support Surfaces section showed the manufacturer's weight recommendations for low air loss beds should be followed. Beds with low air loss features have pressure redistribution configuration that are designed for adults. Review of the NPIAP's Guideline titled Prevention and Treatment of Pressure Ulcers dated 2014 showed the reduction of pressure and shear at the heel is an important point of interest in clinical practice. The posterior prominence of the heel sustains intense pressure, even when a pressure redistribution surface is used. The recommendations showed to inspect the skin of the heels regularly and to ensure the heels are free of the surface of the bed for preventing and treating heel pressure ulcers. Ideally, the heels should be free of all pressure - a state sometimes called floating heels. Pressure on the heels can be relieved by elevating the lower leg and calf from the mattress by placing a pillow under the lower legs, or by using a heel suspension device that floats the heel. Consequently, the pressure will instead spread to the lower legs, and the heels will no longer be subjected to (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure. Review of the facility's P&P titled Wound Care Guidelines revised 11/2021 showed under the Assessment section, the wounds should be measured and evaluated weekly for improvement or decline and the wounds and/or dressings shall be inspected daily and documented. The Documentation section showed the care plans are updated accordingly to reflect the current interventions for the wounds and the long-term interventions to prevent further breakdown as appropriate. Review of the Proactive Medical Products Operational Manual for Protekt Aire 3000/ 3500/ 3600 (undated) showed the Protekt Aire 3000/ 3500/ 3600 System comes with an air cell mattress that provides low air loss, alternate and static pressure redistribution therapy. Protekt Aire 3000 pump and mattress system is indicated for the prevention and treatment of any and all stage pressure ulcers when used in conjunction with a comprehensive pressure ulcer management program. In addition, under the operating instructions, determine the patient's weight and set the control knob to that weight setting on the control unit. Furthermore, review of the Proactive Medical Products Operational Manual for Protekt Aire 3000/ 3500/ 3600 (undated) showed in static mode, the mattress provides a firm surface that makes it easier for the patient to transfer or reposition. The static mode will help ensure the patient does not bottom out when in a sitting position. On 8/12/25 at 1000 hours, during the initial tour of the facility, Resident 138 was observed awake and lying supine in bed on a regular mattress. Resident 138 stated he could not turn or get out of the bed by himself and needed someone to clean him. Resident 138 stated he could sit in the wheelchair, but someone had to put him there. There were two heel protectors observed on the shelf under the TV. Medical record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's care plan for Diabetes Mellitus initiated 7/12/25, showed the interventions included to check all body for breaks in skin and treat promptly as ordered by the physician. Review of Resident 138's H&P examination dated 7/14/25, showed Resident 138 had fluctuating capacity but could make needs known. The H&P further showed Resident 138 had a significant history of Diabetes Mellitus. Review of Resident 138's MDS assessment dated [DATE], showed Resident 138's BIMS Score was 5, indicating cognitively severe impairment. The MDS assessment further showed Resident 138 was dependent for staff assistance on the mobility. The MDS assessment showed Resident 138 was at risk of developing pressure ulcers/injuries. The MDS Skin Conditions section showed Resident 138 had one pressure injury and the Skin and Ulcer/Injury Treatments included pressure reducing device for bed. Review of Resident 138's Order Summary Report showed the following physician orders: - dated 7/19/25, to administer multivitamins minerals oral tablet one tablet via GT one time a day for wound Stage 1 (a reversible, non-blanchable redness on intact skin, usually over a bony prominence, which may also involve changes in skin temperature, texture, or sensation) pressure injury (PI); - dated 7/19/25, to administer vitamin C oral tablet 500 mg one tablet via GT wound Stage 1 pressure (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	injury for 30 days; - dated 7/19/25, to administer zinc sulfate oral tablet 220 mg one tablet via GT one time a day for wound Stage 1 pressure injury for 30 days; - dated 8/8/25, for Resident 138 may have ankle protectors at all times while in bed as tolerated every shift; - dated 8/11/25, to cleanse the right heel DTI (persistent non-blanchable deep red, purple or maroon areas of intact skin, non-intact skin or blood-filled blisters) with normal saline, pat dry, apply skin prep and leave open to air every day shift for 30 days; and - dated 8/12/25, to cleanse coccyx Stage 1 pressure injury with normal saline, apply zinc oxide cream and cover with foam dressing daily and as needed if soiled or dislodged every shift daily for 30 days. a. Review of Resident 138's care plan for Stage 1 pressure injury in the coccyx area revised 7/25/25, showed the interventions included for a LAL mattress for wound management and skin maintenance, monitor every shift for proper functioning, and to adjust to fit comfort of resident. Review of Resident 138's Skin Check dated 7/31/25 at 1725 hours, showed Resident 138 had Stage 1 pressure injury in the coccyx area which was present on admission, measuring 14 cm (length) x 17 cm (width). On 8/14/25 at 0605 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 stated Resident 138's buttocks were red when he cleaned the resident. CNA 3 stated Resident 138 never refused the turning when he needed to be turned. On 8/14/25 at 0626 hours, an interview was conducted with RN 5. RN 5 verified Resident 138 did not have a LAL mattress. On 8/14/25 at 1100 hours, a wound care observation and concurrent interview was conducted with LVNs 1 and 14. Resident 138 stated he was having pain in his sacrum. Resident 138 was observed on a regular mattress. LVN 1 stated Resident 138 already received pain medication. Resident 138's wound in the coccyx area was an open shallow wound with loss of skin and red. LVN 1 stated he did the wound treatment yesterday and it was not like this or could not recall since he had treated several residents yesterday. LVN 1 stated LVN 11 might have seen Resident 138's wound last night because he was told LVN 11 changed the dressing when it got soiled. LVN 1 stated he would restage the coccyx wound and do the change in condition note. LVN 1 verified Resident 138's bed had only a regular mattress. On 8/14/25 at 1140 hours, an interview was conducted via facetime with Family Member 2. Family Member 2 stated Resident 138 was complaining of pain in his buttocks yesterday when she came at around 1700 hours. Family Member 2 stated at around 1900 hours, she asked the CNA to clean Resident 138 because the incontinence brief was wet. Family Member 2 stated when the brief was removed, she observed the coccyx wound was red, open, with the skin was not intact and no dressing. Family Member 2 stated she talked to one of the treatment nurses regarding the coccyx wound but could not recall who. Family Member 2 stated the licensed nurses applied the cream and dressing to Resident 138's coccyx wound. Family Member 2 stated the wound in the coccyx area would get better and heal then come back again. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/14/25 at 1326 hours, an interview and concurrent medical record review was conducted with LVN 11. LVN 11 stated she did the wound treatment yesterday morning and afternoon to Resident 138. LVN 11 stated the coccyx area of Resident 138 yesterday was red, nonblanchable, and the skin was intact, and in the afternoon, the resident's coccyx was extremely red, but the skin was still intact. LVN 11 verified Family Member 2 was in the facility yesterday and she talked to her. LVN 11 verified the resident's plan of care addressing Resident 138's coccyx wound had an intervention for a LAL mattress, but the resident was provided with a regular mattress. LVN 11 further stated the preventative measures to prevent skin breakdown for the residents were frequent repositioning of the resident, providing LAL mattress, RD consult for adequate diet, educating the resident and family members, getting the resident up as often if able to, and implementing IDT meeting. LVN 11 stated the CNAs must complete the shower sheet during shower and document any new skin issue. LVN 11 stated the charge nurse would sign the shower sheet. On 8/15/25 at 1005 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 stated he was familiar with Resident 138 and had provided shower to the resident yesterday morning. CNA 4 stated when he showered Resident 138 yesterday, the wound in the coccyx was red and open. CNA 4 stated he thought he completed the shower sheet when asked if he notified the nurse regarding Resident 138's coccyx area being reopened. CNA 4 stated during the shower, he would check the resident's skin and if he found any skin problems like bruising or wounds, he would write it in the sheet then he would give it to the licensed nurse for signature and inform the licensed nurse of the skin problem. CNA 4 stated he turned his residents every two hours to prevent bed sores. CNA 4 stated if the resident refused, he would report it to the nurse. On 8/18/25 at 1059 hours, an interview was conducted with LVN 7. LVN 7 stated Resident 138 was known to him. LVN 7 stated Resident 138 understood simple English words but did not speak fluent English. LVN 7 stated Resident 138 understood when being asked for pain, turning or cleaning. LVN 7 stated Family Members 1 and 2 usually came to visit Resident 138 so he communicated with the resident through the family members. LVN 7 stated Resident 138 needed full assistance with turning or getting out of the bed to transfer to wheelchair. LVN 7 stated Resident 138 was compliant with care. LVN 7 stated if he saw a new skin problem, he would assess it and document the new skin issue and inform the treatment nurse. LVN 7 stated he had not really seen the coccyx area of Resident 138 last week, but he knew the resident had a Stage 1 pressure injury in the coccyx. LVN 7 stated the CNAs had to complete the shower sheet whenever they provided a shower to the residents and if they found any new wound they would notify the licensed nurses and the licensed nurses had to sign the shower sheet. LVN 7 further stated the CNAs could also document in the tasks, and any skin issues assessed could be documented in the skin check assessment or progress notes in the medical record as well as in the shower sheet. On 8/18/25 at 1155 hours, an observation was conducted for Resident 138. Resident 138 was sleeping in bed on a LAL mattress. The LAL mattress was set to 200 pounds for the weight setting with the static mode turned on with the orange light. On 8/18/25 at 1413 hours, an observation of Resident 138 and concurrent interview was conducted with CNA 5. Resident 138 was awake and lying in the bed on a LAL mattress. The LAL mattress was set to 200 pounds for the weight setting with the static mode turned on with the orange light. CNA 5 verified the setting of the LAL mattress. CNA 5 stated she had not touched the machine since this morning and had not really looked at it until now. CNA 5 stated the LAL mattress should be set to the resident's weight, but she was not familiar with the alternating and static modes of the LAL mattress. CNA 5 stated Resident 138 needed total assistance with mobility and ADL care except for eating. CNA (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5 stated Resident 138 did not refuse any ADL care like turning, being cleaned or elevating his legs when she did it. CNA 5 stated the residents got shower twice a week and Resident 138's shower schedule was every Monday and Thursday. CNA 5 stated when she was giving shower to the residents, she also checked their skin for any bruising or cuts, or infection around the GT, ostomy bag or indwelling urinary catheter, and if she found any she would document it in the shower sheet, would inform the charge nurse right away because the charge nurse needed to sign it as well and would submit the shower sheet to the DSD. CNA 5 further stated if there was a new skin condition or any change in condition for the resident, she would document it also in the Alert task for the CNAs but had not done it because she had never had any residents having a change in condition. On 8/18/25 at 1519 hours, an observation, interview, and concurrent medical record review for Resident 138 was conducted with LVN 1. LVN 1 verified Resident 138's recorded weight was 115 pounds on 8/1/25 per the Weight Record. LVN 1 verified the setting of Resident 138's LAL mattress was wrong and should be based on the resident's weight and comfort and adjust the mattress as necessary. LVN 1 stated at times they had to adjust the weight setting to more than the weight of the resident because the resident could sink in. When asked if the weight setting of 200 pounds appropriate to Resident 138's weight of 115 pounds, LVN 1 stated maybe the resident or family requested it. LVN 1 stated the static mode was used for resident care or repositioning to help maneuver the resident easily. LVN 1 stated the LAL mattress had tiny holes producing layers of air which helped in keeping the residents dry whether it was in static or alternating modes. On 8/19/25 at 1048 hours, an interview and concurrent medical record review for Resident 138 was conducted with the DSD. The DSD stated the CNAs received training for skin assessment as well as part of their orientation. The DSD stated whether it was during shower or bedside care, the CNAs know how to document their findings in the medical record under the Alert task. The DSD stated once the CNA had initiated the Alert task, the licensed nurse would see it in the Progress Note in red letters and had to acknowledge it by starting a change in condition evaluation. The DSD stated the facility's protocol was for the CNA to document Alert in the shower log related to the new skin condition. The DSD stated the CNAs should document in the shower log any skin issues found whether it was new or old. The DSD stated the shower log would be signed off by the charge nurses and if there were new findings related to the skin, she would give the copy to the treatment nurse. The DSD stated the CNAs received training or competency regarding preventative measures to prevent skin injuries which included offloading of bony prominences using pillows or heel protectors. The DSD stated there was nowhere in the medical record the CNA could document the repositioning or offloading the heels were done. The DSD stated the CNAs were given instructions regarding how to set the LAL mattress to static mode only when they were doing ADL care and turn off the static mode when they were done with the care but other than that, they could not touch or change the other setting. The DSD further stated the licensed nurses were responsible for the setting of the LAL mattress alternating mode was used when the resident was not being worked on unless requested by the resident or family member or specified in the order. b. Review of Resident 138's eINTERACT Change in Condition Evaluation dated 8/8/25 at 0615 hours, showed Resident 138 was noted with DTI in the right heel measuring 4 cm (length) x 4 cm (width), with depth unable to determine. Review of Resident 138's Monitor Record for August 2025 showed the ankle protectors were applied on 8/8 for 1900-0700 hours shift, 8/9 to 8/11 for 0700-1900 hours shift and for 1900-0700 hours shift, and 8/12/25 for 0700-1900 hours shift. (continued on next page)

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Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 138's medical record failed to show documented evidence a care plan was developed and continued monitoring/assessment by the licensed nurses for Resident 138's new DTI in the right heel. The medical record also failed to show a weekly skin assessment was completed after 7/31/25. In addition, there was no documentation the right heel was assessed with any redness prior to developing the DTI on 8/8/25. On 8/12/25 at 1257 hours, an observation for Resident 138 and concurrent interview was conducted with Family Member 1. Resident 138 was awake and lying in bed on a regular mattress. The ankle protectors were observed on the shelf below the TV. Family Member 1 stated Resident 138 had been in the facility since July 2025. Family Member 1 stated Resident 138 was not confused. Family Member 1 stated Resident 138's primary language was not English but could understand simple English words. Family Member 1 stated he came to the facility almost every day between 1000 hours to 1200 hours and would stay for two hours, and Family Member 2 came almost every day between 1700 hours to 1900 hours. Family Member 1 stated Resident 138 had a wound on his bottom which would come and go but the right heel back wound was new. Family Member 1 stated Resident 138 never had a wound in the heels before. Family Member 1 stated it was Family Member 2 who found it. Family Member 1 stated every time he came; the ankle protectors were not applied to Resident 138. Family Member 1 stated he would put it on Resident 138 every time he was in the facility. Family Member 1 further stated Resident 138 did not refuse any treatment or care because if the resident did, the facility staff would have informed them. Family Member 1 stated Resident 138 always had a regular mattress since the resident came to the facility. Resident 138 was observed with an eschar in the right heel. On 8/13/25 at 1430 hours, an observation was conducted with Resident 138. Resident 138 was sleeping in the bed on a regular mattress with the tube feed running. Resident 138 did not have the ankle protectors on. On 8/14/25 at 0555 hours, during an observation, Resident 138 was sleeping in bed on a regular mattress without the ankle protectors. The ankle protectors were observed placed on the chair beside Resident 138's bed. On 8/14/25 at 0605 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified Resident 138 was not wearing the ankle protectors. CNA 3 verified Resident 138's heels were resting directly on the mattress. CNA 3 stated Resident 138's right heel was black in color when he cleaned the resident. CNA 3 stated Resident 138 never refused the turning when he needed to be turned. On 8/14/25 at 0626 hours, an interview was conducted with RN 5. RN 5 verified Resident 138 had a DTI on the right heel. RN 5 verified even with one pillow under the resident's legs, the heels were resting directly on the mattress and the resident should always have the ankle protectors while in bed. RN 5 verified Resident 138 did not have a LAL mattress. On 8/14/25 at 1140 hours, an interview was conducted via facetime with Family Member 2. Family Member 2 stated on 8/7/25 at around 1930 hours, she took off Resident 138's socks and observed a blister-like wound with blood about an inch and a half in size on the resident's right heel. Family Member 2 stated Resident 138 complained of pain in his feet occasionally, but it passed. Family Member 2 stated she informed and showed the LVN regarding the right heel of Resident 138. On 8/14/25 at 1326 hours, an interview and concurrent medical record review was conducted with (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 11. LVN 11 stated each day of the week, there were rooms assigned for them to do the weekly skin check. LVN 11 stated Resident 138 was assigned every Thursday for the weekly skin assessment. LVN 11 verified the last weekly skin assessment for Resident 138 was on 7/31/25. LVN 11 stated any new skin issue was considered a change in condition. LVN 11 stated for a change in condition, the licensed nurses must monitor the resident every shift for 72 hours specific to the change in condition. LVN 11 further stated the licensed nurses must monitor if the wound was getting better or worse, responding to the treatment, and if the orders needed to be updated or changed. LVN 11 verified there was no monitoring for Resident 138's DTI on the right heel on 8/8/25. LVN 11 stated if the resident developed a new skin issue and the treatment nurses were no longer in the facility, the report would be given the following morning, and the treatment nurse had to do the complete assessment for the new skin issue. LVN 11 verified the treatment nurse did not complete a skin check/assessment when Resident 138 was identified with DTI in the right heel. LVN 11 stated the care plan should have been developed or revised if there was already an existing care plan addressing the skin integrity of the resident. LVN 11 further stated the care plan was important for monitoring if the treatment plan was helping in the improvement of the new change in condition. LVN 11 verified Resident 138's plan of care failed to show documented evidence a care plan was completed for Resident 138 when the resident developed a DTI in the right heel. LVN 11 stated the wound consultant did not have to follow up residents with DTI because they could heal it. LVN 11 further stated the preventative measures to prevent skin breakdown for the residents were frequent repositioning of the resident, providing low air loss mattress, RD consult for adequate diet, educating the resident and family members, getting the resident up as often if able to, and implementing IDT meeting. On 8/15/25 at 1005 hours, an observation and concurrent interview was conducted with CNA 4. CNA 4 stated he was familiar with Resident 138 and had provided shower to the resident yesterday morning. CNA 4 stated during the shower, he would check the resident's skin and if he found any skin problems like bruising or wounds, he would write it in the sheet then he would give it to the nurse for signature and inform the nurse of the skin problem. CNA 4 stated he could not remember if Resident 138's heels were red the last time he provided a shower to the resident before it became black. CNA 4 stated Resident 138 did not refuse the repositioning or putting pillows under the legs. CNA 4 stated he was not sure where to document in the medical record when he applied the pillows under the legs of the resident or putting on the ankle protectors, but he was doing it. On 8/18/25 at 1059 hours, an interview was conducted with LVN 7. LVN 7 stated Resident 138 was known to him. LVN 7 stated he did not notice redness on Resident 138's heels before it developed into a DTI on the right heel because the resident always wore socks. LVN 7 stated the charge nurses completed a body assessment upon admission. LVN 7 stated the treatment nurse would do the daily skin assessment and weekly skin assessment. LVN 7 stated he would only do a visual check of the resident's body daily of anything he could see but would not remove the socks of the resident to the extent of checking the heels. LVN 7 stated the CNAs had to complete the shower sheet whenever they provided a shower to the residents and if they found any new wound they would notify the licensed nurses, and the nurses had to sign the shower sheet. On 8/18/25 at 1155 hours, an observation was conducted for Resident 138. Resident 138 was sleeping in bed on a LAL mattress and not wearing heel protectors. On 8/18/25 at 1413 hours, an observation of Resident 138 and concurrent interview was conducted with CNA 5. CNA 5 stated she did not know Resident 138 had a DTI in the right heel. On 8/18/25 at 1519 hours, an observation, interview, and concurrent medical record review for (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 138 was conducted with LVN 1. LVN 1 stated he tended to focus on the issue at hand on a daily basis, unless there was a report or change of condition noted and would only do a generalized visual check/look of the skin but not the head-to-toe assessment. LVN 1 stated for the weekly skin check, it was more of assessing the progress of the current wound of the resident and would not really do a complete head to toe skin check or assessment. LVN 1 stated when a new skin issue of the resident was found during the night shift, he would be informed in the morning, or he could run the report for the change in condition report. LVN 1 stated he then needed to follow up the resident and do the skin check assessment with the full description of the wound, size, color, presence of drainage or odor, and the whole general appearance. LVN 1 verified he created a late entry for the weekly skin assessment after 7/31/25, and the follow up skin assessment for Resident 138 after the DTI was identified on 8/8/25. LVN 1 stated for any new skin issues, the change of condition evaluation should be completed and monitor it every shift for 72 hours, implement a care plan for the new skin problem, and if the new skin issue was Stage 3 or 4 and DTI, an IDT meeting should have been initiated. LVN 1 stated the IDT meeting was usually every Tuesday. LVN 1 stated the facility's practice was to do the IDT meeting within 24 hours and circle back to discuss the plan of care. LVN 1 stated the IDT team was composed of him, the DON, IP, and RD. LVN 1 stated he would set up the IDT meeting for Resident 138. LVN 1 stated the wound consultant only saw the residents with infected wounds, Stage 3 and 4 pressure injuries, diabetic foot ulcers, and some DTI. LVN 1 stated the wound consultant would only check on residents with DTI if they have high risk medical diagnosis like Diabetes. LVN 1 verified Resident 138 had a diagnosis of Diabetes Mellitus. LVN 1 stated he would place an order for wound consult for Resident 138. LVN 1 stated the resident was not assessed for any redness in the heel nor reported from the facility staff prior to the identification of the DTI on the right heel. LVN 1 stated prior to the progression of the DTI, the resident might have nonblanchable redness, pain or discomfort to the specific region of the body. LVN 1 stated when he did the skin assessment for the DTI in the right heel of Resident 138 on 8/9/25, the skin felt dense and not mushy, with the skin intact and dark purple in color. LVN 1 stated the CNAs could assess the resident's skin also for any new issues like reddened areas, bruising, and any types of wounds during shower. LVN 1 stated the CNAs would document any findings in the shower sheet and the DSD would give a copy to verify the findings. LVN 1 stated he did not notify the DON when Resident 138 was identified with the right heel DTI and did not know if someone else notified the DON. On 8/19/25 at 1436 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the measures observed by the facility to prevent skin breakdown for the residents included monitoring for skin redness and reporting to the nurses, repositioning the resident every two hours, staff to report all abnormal findings, skin inspections during showers, using pressure release devices, moisture management, and providing adequate nutrition and hydration. The DON stated the licensed nurse should perform a head-to-toe skin assessment daily whether they were charge nurses or treatment nurses. The DON stated the treatment nurses should assess the resid

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services for the use of the GT for three of seven final sampled residents (Residents 41, 94, and138) reviewed for the GT feeding. * The facility failed to ensure the physician's order was followed for Resident 41's enteral feeding. * The facility failed to ensure the HOB (head of the bed) was elevated at a minimum 30-degree angle when the enteral feeding was infusing via GT to reduce the risk of aspiration (entry of food, liquid or foreign material into the airway) for Residents 94 and 138. These failures posed the risk of complications related to the use of GT.Findings: Medical record review for Resident 41 was initiated on 8/12/25. Resident 41 was admitted to the facility on [DATE]. Review of Residents 41's H&P examination dated 9/21/24, showed Resident 41 had no capacity to understand and make decisions. Review of Resident 41's Order Summary Report showed the following physician orders: - dated 7/28/25, to administer continuous enteral feeding with Nepro (enteral feeding) at the rate of 40 ml per hour for 20 hours and total volume of 800 ml, providing 14400 kcal. Start at 1400 hours and off at 1000 hours or until the total volume is completed. - dated 7/28/25, to administer intermittent enteral water flush at the rate of 30 ml per hour for 20 hours. Start at 1400 hours and off at 1000 hours. a. On 8/12/25 at 0856 hours, during the initial tour observation of the facility, Resident 41 was lying in her bed and receiving an enteral feeding of Nepro at the rate of 40 ml/hr via GT and the water flush at 25 ml/hr. On 8/12/25 at 1032 hours, an observation of Resident 41 and concurrent interview was conducted with LVN 6. LVN 6 verified Resident 41 was receiving Nepro at 40 ml/hr and the water needed to be at 30 ml/hr. LVN 6 stated she was in a hurry to change the enteral feeding. b. On 8/19/25 at 1011 hours, an observation and concurrent interview was conducted with LVN 11. Resident 41's Kangaroo pump (medical device used for delivering nutrition directly into the gastrointestinal tract of patients who cannot or drink normally) was turned off. There was still some residual feeding left. LVN 11 stated the feeding for Resident 41 was turned off because the resident completed the feeding volume. LVN 11 turned on the Kangaroo pump and verified Resident 41 did not complete the feeding and needed 242 ml to complete the feeding volume. On 8/19/25 at 1048 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. The DON stated the enteral feeding needed to continue even after 1000 hours to complete the feeding volume ordered. 2. According to Level Up RN, Fundamentals-Practice and Skills part 21: Enteral and Parenteral Nutrition updated 6/30/25, elevate the head of the bed 30-45 degree during feeding and for at least an hour after feeding. This is to reduce the risk of aspiration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 94 was initiated on 8/12/25. Resident 94 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 94's H&P examination dated 7/7/25, showed Resident 94 had no capacity to understand and make decisions. Review of Resident 94's care plan for dysphagia dated 7/11/25, showed interventions including to elevate the HOB at least 30 to 45 degrees during and thirty minutes after the tube feedings. Review of Resident 94's Order Summary Report dated 7/12/25, showed to administer continuous Jevity 1.5 (enteral feeding) at 60 ml per hour for 20 hours and total volume of 1200 ml. To start administration at 1400 hours and stop at 1000 hours or until the total volume was completed. Review of Resident 94's MDS quarterly assessment dated [DATE], under Section I showed Resident 94 had a medical history of dysphagia (difficulty swallowing). On 8/14/25 at 0712 hours, an observation and concurrent interview was conducted with LVN 12. LVN 12 verified Resident 94's HOB was not elevated between 30-45 degrees. LVN 12 confirmed the measurement tool application showed Resident 94's HOB was elevated to 20 degrees while the resident was receiving the enteral feeding. LVN 12 stated Resident 94's HOB should be elevated at least 30 to 45 degrees while receiving the enteral feeding to prevent aspiration. On 8/18/25 at 1613 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings, and stated the HOB for the residents receiving enteral feeding needs to be between 30-45 degrees. 3. Medical record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's H&P examination dated 7/14/25, showed Resident 138 had fluctuating capacity but could make needs known. Review of Resident 138's care plan for enteral feeding dated 7/14/25, showed interventions included the HOB elevated at least 30-45 degrees during and thirty minutes after the tube feedings. Review of Resident 138's Order Summary Report showed a physician's order dated 7/31/25, for continuous enteral feeding with Glucerna 1.2 (type of enteral feeding) at the rate of 75 ml per hour to start at 1400 hours and off at 1000 hours to provide 1500 ml and 1800 kcal per day. On 8/14/25 at 0555 hours, during an observation, Resident 138 was lying in bed and receiving the enteral feeding Glucerna 1.2 at 75 ml per hour via the GT. Resident 138's HOB was observed at a less than 30-degree angle and measured to be at a 20-degree angle. On 8/14/25 at 0605 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 verified Resident 138's HOB was elevated at 20-degree angle while the resident was receiving the enteral feeding via the GT. CNA 3 stated he knew and was familiar with Resident 138 since he had been assigned to the resident most of the time. CNA 3 stated since Resident 138 was receiving the enteral feeding, the HOB for the resident should have been elevated at more than 25-degree angle. CNA 3 further stated Resident 138 was not observed using the bed control or had not requested for (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the HOB to be lowered. On 8/14/25 at 0626 hours, an observation and concurrent interview was conducted with RN 5. RN 5 stated the resident's HOB should be elevated to 30 to 45-degree angle while receiving the enteral feeding to prevent aspiration. RN 5 was informed of and acknowledged the above findings. On 8/19/25 at 1436 hours, an interview was conducted with the DON. The DON stated when the resident was receiving the enteral feeding, aspiration precautions needed to be observed like having the HOB elevated to more than 30-degree angle. The DON was informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for five of five final sampled (Resident 1, 19, 86, 124, and 135) and two non-sampled residents (Resident 40 and 60) reviewed for respiratory care. * The facility failed to ensure the administration of oxygen to Resident 1 was documented. * The facility failed to ensure Resident 19's nasal cannula tubing was labeled and dated. * The facility failed to ensure Resident 40 was administered oxygen per the physician's order. In addition, the facility failed to ensure the humidifier bottle was changed and not left empty for Resident 40. * The facility failed to ensure the nasal cannulas for Resident 60 were stored properly when not in use. * The facility failed to ensure Resident 86's nebulizer storage bag was changed weekly. * The facility failed to ensure a physician's order was obtained prior to the administration of Resident 124's oxygen therapy. In addition, the facility failed to ensure Resident 124's nasal cannula tubing was labeled and dated and a signage was posted to indicate the oxygen was in use. * The facility failed to ensure Resident 135 had an oxygen storage bag to store his nasal cannula. These failures had the potential for these residents not to receive the appropriate respiratory care and increased their risks of infection.Findings: Review of the facility's P&P titled Oxygen Administration revised 11/2021 showed the following: - Set oxygen flow rate as ordered or oxygen percentage (if tracheostomy) as ordered: - Place sign to entry of room alerting that oxygen is in use; and - Change the humidifiers and tubing weekly unless otherwise directed and discard accordingly. If using an antimicrobial storage bags for tubing, may change bags every 30 days. 1. On 8/13/25 at 1142 and 1250 hours, Resident 1 was observed in bed receiving two liters per minute of oxygen via nasal cannula. Medical record review for Resident 1 was initiated on 8/12/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed a physician's order dated 7/24/25, for oxygen to be administered at two liters per minute via nasal cannula as needed. On 8/18/25 at 1016 hours and 8/19/25 at 1044 hours, a follow-up observation was conducted for Resident 1. Resident 1 was observed in a wheelchair receiving two liters per minute of oxygen via nasal cannula. Review of Resident 1's Weights and Vitals Summary for July and August 2025 showed Resident 1's oxygen saturation was monitored while Resident 1 was receiving oxygen via nasal cannula or mask on the following dates and times: - 7/10/25 at 1351 hours; - 7/11/25 at 1833 hours; (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/12/25 at 0941 and 1951 hours; - 7/13/25 at 0910 and 1511 hours; - 7/14/25 at 1555 hours; - 7/16/25 at 0930, 1315 and 1724 hours; - 7/17/25 at 1720 hours; - 7/18/25 at 0900 and 1839 hours; - 7/19/25 at 0902 and 2005 hours; - 7/20/25 at 0903, 1940, and 1941 hours; - 7/21/25 at 0931 hours; - 7/22/25 at 0046, 0100, and 0112 hours; - 7/24/25 at 0301 hours; - 7/25/25 at 1905 hours; - 7/27/25 at 1932 and 1936 hours; - 7/28/25 at 2111 hours; - 8/1/25 at 1832 hours; - 8/2/25 at 1315, 1316 and 1358 hours; - 8/4/25 at 1557 hours; - 8/5/25 at 1600 hours; - 8/6/25 at 1047 and 1807 hours; - 8/9/25 at 0259 and 1405 hours; - 8/11/25 at 1405 and 1839 hours; and - 8/15/25 at 2230 hours. Review of Resident 1's MAR for July and August 2025 failed to show the administration of the oxygen to Resident 1 was documented in the MAR. On 8/19/25 at 1102 hours, an observation for Resident 1 and concurrent interview and medical record review were conducted with LVN 17. LVN 17 verified Resident 1 was receiving oxygen at two liters (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	per minute via nasal cannula. LVN 17 stated Resident 1 was on an on and off oxygen use. When asked if Resident 1 had a low oxygen saturation to warrant the use of the oxygen, LVN 17 stated she had not checked Resident 1's oxygen saturation. LVN 17 stated Resident 1 had a history of shortness of breath. LVN 17 further stated the night shift nurse did not endorse Resident 1 had a low oxygen saturation. When asked where the licensed nurses document of the oxygen administration, LVN 17 stated it should be documented in the MAR. LVN 17 verified the MAR failed to show any documentation when the oxygen was administered to Resident 1. 2. On 8/12/25 at 0932, 0934, 0940, and 1019 hours, Resident 40 was observed in bed with oxygen via nasal cannula at four liters per minute. An empty humidifier bottle dated 8/4/25, was observed connected to the oxygen concentrator. Medical record review for Resident 40 was initiated on 8/12/25. Resident 40 was admitted to the facility on [DATE]. Review of Resident 40's Order Summary Report showed a physician's order dated 5/5/25, for oxygen to be administered at three liters per minute via nasal cannula. On 8/12/25 at 1040 hours, an observation for Resident 40 and concurrent interview was conducted with LVN 3. LVN 3 verified Resident 40 was receiving oxygen via nasal cannula at four liters per minute, and an empty humidifier bottle was dated 8/4/25, was connected to the oxygen concentrator. Upon review of Resident 40's Order Summary Report, LVN 3 verified the physician had prescribed Resident 40 to receive oxygen at three liters per minute. LVN 3 stated the humidifier should have been replaced or changed by the NOC shift nurse weekly. 3. On 8/12/25 at 0904 and 0908 hours, Resident 60 was observed in bed. A green nasal cannula connected to a concentrator was observed on the floor. The set-up bag hanging on the concentrator was dated 8/3/25. Another nasal cannula was also observed on the nightstand and not observed in a set-up bag. Medical record review for Resident 60 was initiated on 8/12/25. Resident 60 was admitted to the facility on [DATE]. Review of Resident 60's Order Summary Report showed a physician's order dated 8/4/25, for oxygen to be administered at two liters per minute via nasal cannula as needed. On 8/12/25 at 0950 hours, an observation for Resident 40 and concurrent interview was conducted with LVN 16. LVN 16 verified the green nasal cannula was on the floor, set-up bag hanging on the concentrator was dated 8/3/25, and another nasal cannula was on the nightstand and not stored in the set-up bag. LVN 16 stated the nasal cannula was changed by the night shift nurse every Sunday. On 8/18/25 at 1521 hours, an interview and concurrent medical record review for Residents 1, 40, and 60 was conducted with the DON. The DON stated the licensed nurses should follow the physician's order when administering the oxygen to the residents and should call the physician if the oxygen needed to be increased. The DON further stated the oxygen administration should be documented in the MAR. When asked about changing the respiratory supplies such as nasal cannulas and humidifiers, the DON stated the respiratory supplies should be changed by the NOC shift nurse every Sunday, and the set-up bag should be labeled with the date, name and room number of the resident. The DON further stated the nasal cannula should be stored inside the set-up bag when not in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. On 8/12/25 at 1100 hours, during the initial tour of the facility, Resident 19 was observed sitting up in a wheelchair and receiving oxygen at two liters per minute via nasal cannula which was attached to a portable oxygen tank. The nasal cannula tubing was unlabeled and undated. In addition, the oxygen concentrator in Resident 19's room had unlabeled and undated nasal cannula. Medical record review for Resident 19 was initiated on 8/12/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's admission MDS assessment dated [DATE], showed Resident 19 had a BIMS of 2 (severely impaired cognition). Review of Resident 19's Order Summary Report for August 2025 showed a physician's order dated 5/7/25, to administer oxygen at two liters per minute via nasal cannula, may titrate oxygen to maintain the oxygen saturation greater or equal to 92% every shift. On 8/12/25 at 1121 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 19's nasal cannula connected to the oxygen concentrator and portable oxygen tank were both unlabeled and undated. LVN 5 stated the nasal cannula should have been labeled and dated. On 8/14/25 at 1317 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 was informed of the above findings. RN 1 acknowledged and stated the nasal cannula were changed by the NOC shift licensed nurses weekly on a Sunday. RN 1 further stated the nasal cannula should be labeled and dated. 5. On 8/12/25 at 1027 hours, during the initial tour of the facility, an oxygen concentrator was observed in Resident 124's room with undated and unlabeled nasal cannula. Additionally, there was no signage to indicate the oxygen was in use in the room. Medical record review for Resident 124 was initiated on 8/12/25. Resident 124 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the Quarterly MDS assessment dated [DATE], showed Resident 124 had a short-term and long-term memory problem. Review of Resident 124's Order Summary Report for August 2025 failed to show a physician's order for the oxygen administration to Resident 124. Review of Resident 124's Change in Condition Evaluation dated 8/4/25, showed the oxygen at two liters per minute via nasal cannula was administered. On 8/12/25 at 1121 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 124's nasal cannula was unlabeled and undated and there was no signage posted to indicate oxygen was in use in the room. LVN 5 stated there should have been a signage for oxygen usage and the nasal cannula should have been labeled and dated. On 8/18/25 at 1605 hours, an interview and concurrent medical record review was conducted with RN 6. RN 6 was informed and acknowledged there should have been a physician's order for the oxygen administration to Resident 124. RN 6 stated the licensed nurses were responsible for changing the nasal cannula weekly and should have been labeled and dated for infection control purposes. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. On 8/12/25 at 0938 hours, during an initial tour of the facility, an observation and concurrent interview with Resident 86 was conducted in the resident's room. The storage bag for Resident 86's nebulizer was dated 8/4/25. When the resident was asked if she uses the nebulizer, Resident 86 stated she does. Medical record review for Resident 86 was initiated on 8/12/25. Resident 86 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 86's H&P examination dated 7/10/25, showed the resident had the capacity to understand and make decisions. Review of Resident 86's Order Summary Report for August 2025, showed a physician's order dated 7/15/25, for albuterol sulfate (a bronchodilator) 3 ml, inhale orally four times a day for COPD. On 8/12/25 at 1046 hours, a follow-up observation and concurrent interview was conducted with LVN 8 in Resident 86's room. LVN 8 verified the storage bag for the nebulizer was dated 8/4/25. LVN 8 stated the storage bag should have been changed weekly for infection control. On 8/18/25 at 1053 hours, an interview with the DSD was conducted. The DSD stated the oxygen and nebulizer storage bags were changed weekly on Sundays during the NOC shift. The DSD stated they should have been changed to ensure infection control. When asked if the storage bags for the oxygen and nebulizers were antimicrobial or regular storage bags, the DSD stated they were regular storage bags. 7. On 8/12/25 at 0955 hours, during an initial tour of the facility, an observation of Resident 135 was made in the resident's room. Resident 135 was observed on the oxygen via nasal cannula; however, there was no oxygen storage bag observed. Medical record review for Resident 135 was initiated on 8/12/25. Resident 135 was admitted to the facility on [DATE]. Review of Resident 135's H&P examination dated 8/3/25, showed the resident was alert. Review of Resident 135's Order Summary Report for August 2025 showed a physician's order dated 7/30/25, for oxygen via nasal cannula at two liters per minute and may titrate the oxygen to maintain the oxygen saturation greater or equal to 92% every shift. On 8/12/25 at 1046 hours, a follow-up observation and concurrent interview was conducted with LVN 18 in Resident 135's room. LVN 18 verified the above findings and stated Resident 135 was on continuous oxygen. LVN 18 stated Resident 135 should have a storage bag when the resident removes the nasal cannula and uses a portable oxygen tank and leaves the room. LVN 18 stated the storage bags were provided to ensure the nasal cannula tubing does not go on the floor and maintain the infection control. LVN 18 further stated the storage bags were changed weekly during NOC shift. On 8/19/25 at 1008 hours, an interview was conducted with the DON. The DON stated she expected her license nurses to change the storage bags for the oxygen and nebulizers weekly every Sundays and ensure the storage bags were dated. The DON was informed and acknowledged the above findings for Residents 86 and 135.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary dialysis care for four of five final sampled residents (Residents 1, 9, 41, and 116) reviewed for dialysis. * The facility failed to monitor Resident 1's fluid intake and specify the fluid restriction per the physician's order. In addition, the facility failed to ensure Resident 1's dialysis access assessments pre- and post-dialysis were accurate and complete, and Resident 1's BP (blood pressure) was not taken on the right upper extremity. Furthermore, the facility failed to ensure the medications scheduled to be administered to Resident 1 on the days the resident had dialysis treatments had a physician's order to be held or were rescheduled. * The facility failed to ensure Resident 9's Dialysis Communication Forms were completed on multiples dates. * The facility failed to ensure Resident 41's BP access site was accurately documented in the resident's medical record. * The facility failed to ensure Resident 116's Dialysis Communication Forms were accurate and complete. These failures had the potential for the residents not to be provided with the appropriate care and treatment and the potential for medical complications related to dialysis. Findings: 1. Review of the facility's P&P titled Dialysis Resident, Care of revised 11/2021 showed the following: - It is the policy of the facility to provide care to the dialysis resident in accordance with physician's orders, to maintain the patency of the AV shunt (arteriovenous also known as an AV fistula or AV graft, is a surgical connection between an artery and a vein to provide access to the blood for dialysis) or CVC (Central Venous Catheter), and to minimize risks of complications from the AV shunt or CVC; - Dialysis assessments are to be completed pre- and post-dialysis for outpatient dialysis; - Medications on days of dialysis shall be held in accordance with physician's orders, if any; and - Fluid restrictions per physician's order. If on fluid restrictions, monitor intake and output only upon physician's order. Medical record review for Resident 1 was initiated on 8/12/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following physician's orders: - dated 7/8/25, to administer docosanol external cream (antiviral medication) 10% to the affected area topically five times a day; - dated 7/12/25, to administer Vancomycin (antibiotic medication) 125 mg capsule by mouth four times a day for 10 days. This medication was discontinued on 7/21/25; - dated 7/23/25, to administer Novasource (oral nutrition supplement) by mouth two times a day; - dated 7/23/25, to administer apixaban (anticoagulant medication) 2.5 mg by mouth two times a day; - dated 7/23/25, to administer ascorbic acid (supplement) 250 mg by mouth two times a day; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 7/23/25, to administer budesonide (corticosteroid medication) 0.5mg/2 ml via inhalation two times a day; - dated 7/23/25, to administer guaifenesin (expectorant medication) 600 mg by mouth two times a day; - dated 7/23/25, to administer metoprolol (antihypertensive medication) 25 mg 0.5 tablet by mouth two times a day; - dated 7/24/25, to monitor the hemodialysis access site, tunneled Permacath, on the right upper chest every shift and as needed; - dated 7/24/25, to have hemodialysis on Tuesdays, Thursdays, and Saturdays at 1450 hours, with the chair time at 1520 hours; and - dated 7/31/25, for fluid restriction at 1500 ml/24 hours, to specify. a. Further review of Resident 1's medical record failed to show the fluid restriction order specified the exact amount the resident should receive from the nursing staff and dietary services. Review of Resident 1's POC Response History showed Resident 1's fluid intake ranged from 240 to 1000 ml per day. The report also showed Resident 1's fluid intake was not consistently monitored as his fluid intake was documented as response not required on 7/24, 7/26, 7/27, 7/28, 7/29, 7/31, 8/2, 8/5, and 8/9/25. On 8/12/25 at 0847 hours, 8/13/25 at 1128 and 1142 hours, and 8/14/25 at 0603 hours, Resident 1 was observed in bed, with a water pitcher on the bedside table. On 8/14/25 at 1033 hours, an observation for Resident 1 and concurrent interview was conducted with CNA 2. CNA 2 verified Resident 1 had a water pitcher at bedside. When asked about Resident 1's fluid intake, CNA 2 stated Resident 1 drank the water from his water pitcher and the fluids from his meal trays. When asked if Resident 1's fluid intake was being monitored, CNA 2 stated he just checked when the water pitcher was empty, but he did not know how long he had the water or how long the resident drank the water from the pitcher. CNA 2 stated he only documented Resident 1's fluid intake from the meal trays. CNA 2 stated he was not informed Resident 1 was on fluid restriction, but he knew Resident 1 was on dialysis. CNA 2 stated Resident 1 went to dialysis at around 1450 to 1500 hours. On 8/14/25 at 1101 hours, an interview and concurrent medical record review was conducted with LVN 6. When asked if Resident 1's fluid intake was being monitored, LVN 6 stated she monitored Resident 1's fluid intake during the medication administration and documented the resident's intake in the MAR. LVN 6 reviewed Resident 1's MAR, which failed to show documentation of Resident 1's fluid intake from the nursing services. LVN 6 stated she knew there was a physician's order for Resident 1's fluid restriction, and maybe the CNAs document it. On 8/14/25 at 1129 hours, an interview and concurrent medical record review was conducted with LVN 11. When asked about Resident 1's fluid restriction, LVN 11 verified there was no breakdown of the exact amount Resident 1 should receive from nursing staff and dietary services department. When asked if Resident 1's fluid intake was being monitored, LVN 11 verified there was no documentation (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the licensed nurses for the resident's fluid intake in the MAR. LVN 11 stated the CNAs were documenting the fluid intake from the meal trays. LVN 11 verified the CNAs were not consistently monitoring Resident 1's fluid intake from the meal trays. When asked how they monitor Resident 1's fluid intake from his water pitcher, LVN 11 stated the residents on fluid restriction should not have a water pitcher. On 8/14/25 at 1140 hours, LVN 11 verified a water pitcher was observed at Resident 1's bedside. On 8/19/25 at 1122 hours, an interview and facility document record review was conducted with the DSS. The DSS stated the dietary services provided the fluid based on what was recommended and what the residents preferred. The DSS further stated for the residents on fluid restriction, the fluids provided from the dietary services to the residents were based on the Fluid Distribution Grid. Review of the facility's document titled Fluid Distribution Grid (undated) showed the total fluid intake from nursing services was 780 ml with a breakdown of 300 ml for the day shift, 300 ml for the afternoon shift, and 180 ml for the night shift. The total fluid intake from the dietary services was 720 ml, with a breakdown of 240 ml for breakfast, 240 ml for lunch, and 240 ml for dinner. The DSS further stated there was no breakdown given as per the physician's order, but the dietary services only followed the Fluid Distribution Grid. The DSS stated residents on fluid restrictions should not have any water pitcher at bedside, and no extra water was given. b. Review of Resident 1's Dialysis Communication Forms showed the following: - The Pre-Dialysis Information section was not filled out completely to show the medications administered prior to dialysis on 7/10, 7/12, 7/17, 7/21, 7/26, 7/29, 7/31, 8/5, 8/7, 8/9, and 8/12/25; and -The Post-Dialysis Information section showed Resident 1, who had a right upper chest CVC, was assessed with bruit and thrill on 7/12, 7/15, 7/17, 7/21, and 8/2/25. In addition, Resident 1's right upper chest CVC was not assessed for bleeding on 7/26, 7/31, 8/2, and 8/5/25. On 8/14/25 at 1129 hours, an interview and concurrent medical record review was conducted with LVN 11. LVN 11 verified Resident 1's Dialysis Communication Forms were incomplete and inaccurate. LVN 11 stated there were no bruit and thrill for residents with CVC. c. Review of Resident 1's Care Plan Report showed a special instruction to not take the resident's BP on the right upper extremities. Review of Resident 1's Weight and Vitals Summary showed Resident 1's blood pressure was taken on the right arm on the following dates and times: - 8/1/25 at 1025 and 1832 hours; - 8/2/25 at 0942 and 1023 hours, - 8/5/25 at 1600 hours; - 8/7/25 at 0933 hours, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/10/25 at 0955, 1035, and 1636 hours, - 8/11/25 at 2248 hours, - 8/13/25 at 1333 hours, - 8/14/25 at 1033 hours, and - 8/16/25 at 1012 and 1350 hours On 8/18/25 at 1111 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 1's BP was taken on the right upper arm per the documentation of his BP readings listed above. RN 2 stated the BP should not be taken on the right upper arm because of the possibility of occlusion of the resident's Permacath (a type of tunneled, cuffed catheter used for dialysis in patients with kidney failure, providing access to the bloodstream for removing and returning blood) on the right upper chest. d. Review of Resident 1's MAR for July and August showed the following medications were held and not administered to Resident 1: - vancomycin 125 mg at 1700 hours on 7/10, 7/12, 7/19, and 7/21/25; - docosanol cream at 1700 hours on 7/10, 7/12, 7/19, and 7/21/25, - apixaban 2.5 mg at 1700 hours on 7/8, 7/12, 7/19, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12 and 8/16/25; - ascorbic acid 250 mg at 1700 hours on 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12 and 8/16/25; - budesonide 0.5mg/2 ml at 1700 hours on 7/10, 7/12, 7/19, 7/21, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25; - guaifenesin 600 mg at 1700 hours on 7/10, 7/12, 7/19, 7/21, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25; - metoprolol 25 mg 0.5 tablet at 1700 hours on 7/10, 7/12, 7/19, 7/21, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25; and - Novasource supplement at 1700 hours on 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25. Further review of Resident 1's medical record failed to show a physician's order to hold or reschedule the administration of Resident 1's medications during the dialysis days. On 8/18/25 at 1111 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 1's medications were not administered during his dialysis. RN 2 further verified there were no physician's order to hold the medications during Resident 1's dialysis days. On 8/18/25 at 1547 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. The DON verified the fluid restriction order did not specify (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the exact amount the resident should receive from the nursing staff and dietary services. The DON stated the dietary services had a breakdown of the fluid restriction. The DON stated the fluid intake monitoring included the fluid intake from the water pitcher at bedside, meal trays, and during medication pass. The DON stated the water pitcher at bedside was about 2000 ml. The DON verified the CNAs' documentation did not show the resident's fluid intake from the medication pass, and also did not show the fluid intake by the resident during the NOC shift. When asked about Resident 1's Dialysis Communication Form, the DON stated the charge nurses had to complete the form before and after dialysis. When asked about taking the BP on the right upper extremity, the DON stated this was a special instruction from the resident's care profile. The DON stated the BP should not be taken on the right upper extremity because of the resident's Permacath on the right upper chest. When asked about the medications not given on dialysis days, the DON stated Resident 1's medications scheduled to be administered during the dialysis appointments should have been communicated to the physician so the medication administration schedule could have been adjusted or the licensed nurses should have obtained a physician's order to hold the medications. Cross reference to F760. 2. Review of the facility's P&P titled Dialysis Resident, Care Of dated October 2024 showed the dialysis assessments are to be completed post dialysis for outpatient dialysis residents. Medical record review for Resident 116 was initiated on 8/15/25. Resident 116 was admitted to the facility on [DATE], with the diagnoses of end stage renal disease (medical condition where the kidneys lost most of their function) requiring dialysis three days a week and a long-term implanted dialysis access catheter (Permacath). Review of Resident 116's Dialysis Communication Form dated 7/28/25, showed the section indicated for the assessment of the dialysis access post dialysis was incorrectly marked yes for presence of bruit and thrill of the resident's Permacath. Review of Resident 116's Dialysis Communication Forms dated 8/5 and 8/8/25, showed the section indicated for the assessment of the dialysis access dressing post dialysis was left blank. On 8/15/25 at 0844 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified Resident 116 had a Permacath dialysis access. RN 3 further verified the above findings. RN 3 verified Resident 116's Permacath dialysis access did not have a bruit and thrill, however, Resident 116's Dialysis Communication Form dated 7/28/25, showed yes was documented in the post dialysis bruit and thrill assessment section. 2. Medical record review for Resident 9 was initiated on 8/14/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's H&P examination dated 4/18/25, showed the resident had the capacity to understand and make decisions. Review of Resident 9's Order Summary Report dated 8/14/25, showed the following physician's order: - dated 4/17/25, for hemodialysis every Tuesdays, Thursdays, and Saturdays at the dialysis center. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 4/7/25, for hemodialysis access site monitoring, type: Port-A-Cath (a type of vascular access device used for dialysis, particularly when other options like AV fistulas or grafts are not suitable or available. It's a surgically implanted device with a catheter leading to a large vein, allowing for repeated access for dialysis treatments), left thigh site dressing changes at dialysis center and as needed, monitor access site for signs and symptoms of infection every shift. - dated 5/13/25, for hemodialysis access site monitoring, type: Port- A-Cath, right thigh site dressing changes at dialysis center and as needed. Review of Resident 9's Dialysis Communication Forms showed the post-hemodialysis information section failed to show completed assessment documentation of the catheter site on the following dates: 7/1, 7/8, 7/15, 7/22, 7/29, 8/9, and 8/12/25. On 8/14/25 at 0915 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator for Resident 9. The MDS coordinator verified the above findings. On 8/14/25 at 1125 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON further stated if the assessment was not documented then it was not done. 3. Review of the facility's P&P titled Dialysis Resident, Care of revised 10/2024 showed to maintain the AV shunt functionality by restricting the following in the shunt arm: a. No blood pressure; b. No IM injections; and c. No restraints with the rare exception of a mitten which may be placed loosely on the affected extremity in accordance with the procedures for use of physical restraints. Medical Record Review for Resident 41 was initiated on 8/12/25. Resident 41 was admitted to the facility on [DATE]. Review of Residents 41's H&P examination dated 9/21/24, showed Resident 41 had no capacity to understand and make decisions. Review of Resident 41's plan of care showed a care plan problem dated 7/5/25, addressing the resident's need for a hemodialysis related to renal failure. The interventions included not to draw blood, no IM (intramuscular) injections or take blood pressure on the resident's left arm with the fistula. Review of Resident 41's Blood Pressure Summary showed the documentation for the resident's BP reading was obtained on the left arm on the following dates and times: - On 7/30/25 at 0833 hours, the resident's blood pressure was 130/67 mmHg; - On 7/31/25 at 0614 hours, the resident's blood pressure was 138/85 mmHg; - On 8/1/25 at 0551 hours, the resident's blood pressure was 128/64 mmHg; (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 8/2/25 at 2203 hours, the resident's blood pressure was 102/47 mmHg; - On 8/3/25 at 0836 hours, the resident's blood pressure was 148/61 mmHg; - On 8/3/25 at 1337 hours, the resident's blood pressure was 136/64 mmHg; - On 8/5/25 at 1055 hours, the resident's blood pressure was 136/64 mmHg; - On 8/7/25 at 2131 hours, the resident's blood pressure was 112/65 mmHg; - On 8/9/25 at 2122 hours, the resident's blood pressure was 112/41 mmHg; - On 8/10/25 at 0522 hours, the resident's blood pressure was 106/46 mmHg; and - On 8/16/25 at 0606 hours, the resident's blood pressure was 126/54 mmHg. On 8/12/25 at 0856 hours, during the initial tour of the facility, an observation was conducted in Resident's 41 room. Resident 41 was observed lying in her bed, on the head of bed wall there was a note, No blood pressure on the left arm. Review of Resident 41's Order Summary Report dated 8/13/25, showed a physician's order dated 7/23/25, for AV fistula on the left forearm. On 8/18/25 at 0951 hours, an interview and concurrent medical record review for Resident 41 was conducted with LVN 9. LVN 9 was asked about the dialysis access for Resident 41. LVN 9 stated Resident 41 had a left forearm AV fistula and should have not taken the resident's blood pressure on the left upper arm. LVN 9 verified the above findings. On 8/18/25 at 1613 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. The DON stated the resident's blood pressure should not have been taken on the left upper arm, where the AV Fistula was located. 4. Review of the facility's P&P titled Dialysis Resident, Care Of dated October 2024 showed the dialysis assessments are to be completed post dialysis for outpatient dialysis residents. Medical record review for Resident 116 was initiated on 8/15/25. Resident 116 was admitted to the facility on [DATE], with the diagnoses of end stage renal disease (medical condition where the kidneys lost most of their function) requiring dialysis three days a week and a long-term implanted dialysis access catheter (Permacath). Review of Resident 116's Dialysis Communication Form dated 7/28/25, showed the section indicated for the assessment of the dialysis access post dialysis was incorrectly marked yes for presence of bruit and thrill of the resident's Permacath. Review of Resident 116's Dialysis Communication Forms dated 8/5 and 8/8/25, showed the section indicated for the assessment of the dialysis access dressing post dialysis was left blank. On 8/15/25 at 0844 hours, an interview and concurrent medical record review was conducted with RN 3. RN 3 verified Resident 116 had a Permacath dialysis access. RN 3 further verified the above (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	findings. RN 3 verified Resident 116's Permacath dialysis access did not have a bruit and thrill, however, Resident 116's Dialysis Communication Form dated 7/28/25, showed yes was documented in the post dialysis bruit and thrill assessment section.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure three of 28 final sampled residents (Resident 2, 5, and 138) were free from the unnecessary drugs. * Resident 2 was administered metoprolol (medication to treat high blood pressure) on numerous occasions when Resident 2's BP (blood pressure) was below the parameter prescribed by the physician. In addition, Resident 2 was administered midodrine (medication to treat low blood pressure) on numerous occasions when Resident 2's BP was above the parameter prescribed by the physician. Furthermore, the facility failed to ensure Resident 2's antibiotic was held when an adverse side effects were documented. * The facility failed to ensure Resident 5's anticoagulant was held when an adverse side effects were documented. * The facility failed to monitor Resident 138 for the signs and symptoms of bleeding related to the use of apixaban (medication used to treat or prevent blood clots). In addition, the facility failed to ensure Resident 138's anticoagulant medication was held when an adverse side effects were documented.These failures had the potential for the residents to develop medical complications for not accurately administering the medications per the physician's orders. Findings: 1. Medical record review for Resident 2 was initiated on 8/12/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report showed the following physician's orders: - dated 4/6/25, to administer metoprolol 25 mg one tablet by mouth two times a day, and hold if hold if the SBP was less than 120 mmHg, or the heart rate was less than 60 beats per minute; - dated 8/3/25, to administer Keflex (antibiotic medication) 500 mg by mouth four times a day; and - dated 8/3/25, to monitor for adverse side effects of antibiotic therapy for Keflex medication: fatigue, headache, chills, rash, fever, diarrhea, nausea and vomiting, feeling unwell; and to notify the physician as needed every shift Review of Resident 2's MARs for July and August 2025 showed the following: a. Resident 2 was administered the metoprolol medication when the resident's BP was below 120 mmHg, and the heart rate was less than 60 beats per minute: - on 7/1/25 at 0900 hours, with a BP of 103/78 mmHg; - on 7/8/25 at 1700 hours, with a BP of 106/68 mmHg; - on 7/12/25 at 1700 hours, with a BP of 99/58 mmHg; - on 7/14/25 at 1700 hours, with a BP of 98/61 mmHg, and a heart rate of 58 beats per minute - on 7/27/25 at 1700 hours, with a BP of 96/68 mmHg; - on 7/31/25 at 1700 hours, with a BP of 90/50 mmHg; - on 8/4/25 at 1700 hours, with a BP of 97/59 mmHg; and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- on 8/6/25 at 0900 hours, with a BP of 101/73 mmHg; b. Resident 2 was documented to have signs and symptoms of bleeding related to the use of abixaban medication on 7/13, 7/14, 7/21, 7/27, 7/28, 8/3, 8/4, 8/10, and 8/11/25 from 1900 to 0700 hours shift. On 8/18/25 at 1047 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the above findings. RN 2 stated a checkmark on the MAR meant it was given. RN 2 verified the metoprolol medication was administered to Resident 2 outside the BP and heart rate parameters prescribed by the physician. When asked about the monitoring for the adverse reactions related to the use of the Keflex medication, RN 2 stated yes documentation meant adverse reactions were observed. RN 2 stated the licensed nurses also documented in the resident's progress notes. Review of Resident 2's Progress Notes showed documentation Resident 2 did not have adverse reactions from the Keflex medication on 7/13/25 at 2215 hours, 7/14/25 at 2106 hours, 8/3/25 at 2226 hours, 8/10/25 at 2108 hours, and 8/11/25 at 2247 hours. However, review of Resident 2's Progress Notes failed to show documentation the physician was notified when Resident 2 was observed with adverse reactions related to the use of Keflex medication on 7/21, 7/27, 7/28, and 8/4/25 from 1900 to 0700 hours shift. RN 2 verified the above findings. 2. Medical record review for Resident 5 was initiated on 8/12/25. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Order Summary Report showed the following physician's orders: - dated 7/22/25, to administer enoxaparin (anticoagulant medication) 0.8 ml subcutaneously every 12 hours; and - dated 7/26/25, to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic area, petechiae. If my initial N is noted, it means I've observed signs and symptoms, hold anticoagulant/antiplatelet dose and notify MD. If my initial Y is noted, it signifies the absence of the listed signs and symptoms. every shift; - dated 8/3/25, to administer Keflex 500 mg by mouth four times a day; and - dated 8/3/25, to monitor for adverse side effects of antibiotic therapy for Keflex medication: fatigue, headache, chills, rash, fever, diarrhea, nausea and vomiting, feeling unwell; and to notify the physician as needed every shift. Review of Resident 5's MAR for August 2025 showed Resident 5 was administered the enoxaparin medication from 8/1 to 8/18/25 at 0900 and 2100 hours. Further review of the MAR under the monitoring for signs and symptoms of bleeding, where N meant signs and symptoms of bleeding were observed, held the anticoagulant medication and notified the physician, showed no was documented at 0700 to 1900 hours shift on 8/1 to 8/18/25, and from 1900 to 0700 hours shift on 8/1, 8/2, 8/5 to 8/9, and 8/12 to 8/16/25. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/18/25 at 1028 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified the above findings. RN 2 stated the anticoagulant medication should have been held when signs and symptoms were observed. RN 2 verified Resident 5 was administered the enoxaparin medication even when Resident 5 was documented to have signs and symptoms of bleeding in the MAR. RN 2 further verified Resident 5's medical records did not show documented evidence of the notification to the physician when the signs and symptoms of the bleeding was observed. 3. Medical record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's H&P examination dated 7/14/25, showed Resident 138 had fluctuating capacity but could make needs known. Review of Resident 138's Order Summary Report showed the following physician's orders: - dated 7/11/25, to administer apixaban one tablet via GT two times a day for DVT (deep vein thrombosis, blood clot) prophylaxis; and - dated 7/26/25, to monitor for any of the following: blood in the urine, blood in the stool, unusual bleeding after shaving, bleeding from the gums, bleeding from the nose, excessive bleeding from wounds, large hemorrhagic area (tiny or large patches of red, purple, blue or black spots which indicate bleeding into the skin), petechiae (tiny round brown-purple spots in the skin) every shift. If the initial N was noted, it meant signs and symptoms were observed, hold anticoagulant dose and notify the physician. If the initial Y was noted, it signified the absence of the listed signs and symptoms. Review of Resident 138's care plan for the use of anticoagulant dated 7/14/25, showed interventions included monitoring/documenting/reporting as needed the adverse reactions to anticoagulation therapy. Review of Resident 138's MAR for July 2025 and August 2025 showed Resident 138 received the apixaban on 7/12 to 7/31/25 at 0900 hours and at 1700 hours, and on 8/1 to 8/14/25 at 0900 hours and at 1700 hours and on 8/15/25 at 0900 hours. Further review of the MAR for July 2025 to August 2025 under the monitoring for signs and symptoms of bleeding did not show documented evidence Resident 138 was being observed for signs and symptoms of bleeding from 7/12 to 7/26/25. In addition, the MAR showed no was documented on the following days: - 7/27 and 7/28/25 at 0900 hours; - 7/29 to 8/2/25 at 0900 hours and at 1700 hours; - 8/3 to 8/4/25 at 0900 hours; - 8/5 to 8/9/25 at 0900 hours and at 1700 hours; - 8/10 to 8/11/25 at 0900 hours; - 8/12 to 8/14/25 at 0900 hours and at 1700 hours; and (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 8/15/25 at 0900 hours. On 8/15/25 at 1103 hours, an interview and concurrent medical record review for Resident 138 was conducted with RN 3. RN 3 verified the above findings. RN 3 verified Resident 138 was not monitored for signs and symptoms of bleeding related to the use of apixaban until 7/27/25. RN 3 verified Resident 138 was administered the apixaban medication even when Resident 138 was documented to have signs and symptoms of bleeding in the MAR for July and August 2025. RN 3 further verified Resident 138's medical records did not show documented evidence of notification to the physician when the signs and symptoms of bleeding were observed. On 8/19/25 at 1436 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5% during medication pass observation. The facility's medication error rate was 6.9%. One of four licensed nurses (LVN 7) was found to have made errors during the medication administration. * Resident 138 had a physician's order for Nystatin Suspension (antifungal medication) 100000 unit/ml give 5 ml by mouth four times a day for oral thrush, swish and swallow. LVN 7 instructed Resident 138 to swish and spit, rather than swish and swallow, and did not follow the bold writing instructions on the label on the medication bottle to shake the Nystatin Suspension prior to the administration of the medication. * Resident 138 had a physician's order for Lansoprazole capsule (a medication used to treat acid reflux and heartburn) delayed release 30 mg give one capsule through the GT two times a day. LVN 7 did not administer the medication as ordered by the physician. These failures resulted in the resident not receiving the medications as ordered by the physician and had the potential to compromise the health and safety of the resident.Findings: Review of the facility's P&P titled Medication Administration-General Guidelines dated 10/2017 showed the medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. The facility has sufficient staff to allow administering of medications without unnecessary interruptions. Additionally, under the administration section, medications are administered in accordance with written orders of the attending physician. On 8/12/25 at 0818 hours, a medication administration observation for Resident 138 was conducted with LVN 7. LVN 7 was observed preparing and administering the following medications:- amiodarone (medication to treat or prevent irregular heartbeats) 200 mg tablet;- entecavir (an antiviral medication used to treat long-term Hepatitis B infection) 0.5 mg tablet;- Eliquis (medication to prevent and treat blood clots) 5 mg tablet;- vitamin D3 (supplement to support strong bones, muscles, and overall health) 1000 unit tablet;- multi-vitamins with minerals tablet (supplements);- nystatin (antifungal) 100,000 unit/ml suspension - 5 ml;- polyethylene glycol (laxative to treat occasional constipation) 3350 powder - 17 grams;- senna (laxative to treat occasional constipation) oral syrup 8.8 mg/5ml - 5 ml;- zinc (supplements) 50 mg tablet; and- vitamin C (supplements) 500 mg tablet. LVN 7 was observed preparing the nystatin suspension without shaking the bottle prior to pouring the medication into a medication cup, as shown on the instructions on the label on the medication bottle. In addition, LVN 7 was observed giving verbal instructions to Resident 138 to swish and spit the nystatin suspension medication, instead of to swish and swallow as ordered by the physician. Medical Record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's Order Summary Report dated 8/12/25, showed a physician's order dated 7/11/25, for lansoprazole delayed release 30 mg capsule, give one capsule via GT two times a day for GERD (Gastroesophageal reflux disease, is a condition in which the stomach contents leak backward from the stomach into the esophagus). However, during the medication administration, the lansoprazole medication was not administered. Further review of Resident 138's Order Summary Report dated 8/12/25, showed a physician's order dated 8/1/25, for nystatin suspension 100,000 unit/ml, give 5 ml by mouth four times a day for oral thrush until 8/15/25, swish and swallow. On 8/12/25 at 1505 hours, an interview was conducted with LVN 7. LVN 7 was informed and verified the findings. LVN 7 stated Resident 138 was out of the lansoprazole medication and has forgotten to follow-up with the pharmacy since he was not able to select the option in the Point Click Care (a software used for electronic health records to reorder the medication). LVN 7 stated he did not administer the medication to Resident 138 for two days. On 8/14/25 at 0856 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure Resident 1 was free from significant medication errors for one of 28 final sampled residents (Resident 1). * The facility failed to ensure the vancomycin (antibiotic medication), apixaban (anticoagulant medication), and metoprolol (antihypertensive medication) medications scheduled to be administered to Resident 1 on the days the resident had dialysis treatments had a physician's order to be held or were rescheduled. In addition, the facility failed to notify the physician when these medications were not administered to Resident 1. This failure placed Resident 1 at risk for significant side effects and medical complications.Findings: According to dailymed.com (an online reference for clinical drug information):- For the vancomycin (antibiotic) medication, under the Patient Counseling Information section, although it is common to feel better early in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by vancomycin hydrochloride capsules or other antibacterial drugs in the future;- For the apixaban (anticoagulant) medication, under the Boxed Warning section, premature discontinuation of any oral anticoagulant, including apixaban tablets, increases the risk of thrombotic events. If anticoagulation with apixaban tablets is discontinued for a reason other than pathological bleeding or completion of a course of therapy, consider coverage with another anticoagulant. - For the metoprolol (antihypertensive) medication, under Warnings and Precautions section, following abrupt cessation of therapy with beta adrenergic blockers, exacerbations of angina pectoris and myocardial infarction may occur. Medical record review for Resident 1 was initiated on 8/12/25. Resident 1 was readmitted to the facility on [DATE]. Review of Resident 1's Order Summary Report showed the following physician's orders:- dated 7/12/25, to administer vancomycin 125 mg capsule by mouth four times a day for 10 days. This medication was discontinued on 7/21/25;- dated 7/23/25, to administer apixaban 2.5 mg by mouth two times a days;- dated 7/23/25, to administer metoprolol 25 mg 0.5 tablet by mouth two times a day;- dated 7/24/25, scheduled to have hemodialysis on Tuesdays, Thursdays, and Saturdays at 1450 hours, with the chair time at 1520 hours. Review of Resident 1's MAR for July and August 2025 showed the following medications were held and not administered to Resident 1:- vancomycin 125 mg at 1700 hours on 7/10, 7/12, 7/19, and 7/21/25;- apixaban 2.5 mg at 1700 hours on 7/8, 7/12, 7/19, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25; and- metoprolol 25 mg 0.5 tablet at 1700 hours on 7/10, 7/12, 7/19, 7/21, 7/26, 7/29, 7/31, 8/2, 8/5, 8/7, 8/12, and 8/16/25. Review of Resident 1's medical record failed to show a physician's order to hold or reschedule the administration of Resident 1's medications during his dialysis days. Further review of Resident 1's medical record failed to show the documentation the physician was notified when Resident 1 was not administered the vancomycin, apixaban and metoprolol medications. On 8/18/25 at 1111 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 1's above medications were not administered during his dialysis. RN 2 further verified there were no physician's order to hold the medications during Resident 1's dialysis days. On 8/18/25 at 1547 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the above findings. When asked about the medications not given on dialysis days, the DON stated Resident 1's medications scheduled to be administered during the dialysis appointments should have been communicated to the physician so the medication administration schedule could have been adjusted or the licensed nurses should have obtained a physician's order to hold the medications. The DON verified the physician was not notified when Resident 1 was not administered the vancomycin, apixaban, and metoprolol medications. Cross reference to F698, example # 1.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure medications were stored as per the facility's P&P and outdated medications and medical supplies were not available for residents' use. * The facility failed to ensure orally administered medications were kept separate from externally used medications in Medication Rooms A and B, and Medication Cart A. * The facility failed to ensure the expired medications and medical supplies were not available for resident use in Medication Carts B and C. * The facility failed to ensure for safe storage of the medications observed at the bedside for Residents 2, 23, 25, 97, and 138. These failures had the potential to result in unsafe medication administration and negatively impact the residents' well-being.Findings: Review of the facility's P&P titled Storage of Medications, revised January 2025 showed orally administered medications are kept separate from externally used medications, such as suppositories, liquids, and lotions. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. 1. a. On 8/13/25 at 0951 hours, an inspection of Medication Room A and concurrent interview was conducted with the Central Supply staff. During the inspection of the Medication Room, there was a bottle of eye drops (external medication) stocked next to acidophilus (oral supplement). The Central Supply staff acknowledged and verified the findings. b. On 8/13/25 at 1018 hours, an inspection of Medication Room B and concurrent interview was conducted with the MDS Coordinator. During the inspection of Medication Room B, the following was identified: - a deep sea premium saline spray was stored next to vitamin B1 tablets (supplement). - two povidone-iodine Swabsticks (an antiseptic used for skin disinfection) had an expiration date of 7/25/25. - two injection needles with BD Luer-Lok syringe had an expiration date of 2/8/25. - two luer slip disposable syringe without needles had an expiration date of 8/10/25. The MDS Coordinator acknowledged and verified the findings. c. On 8/13/25 at 1122 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 9. During the inspection of Medication Cart A, there were iron tablets and nitroglycerin (medication for chest pain) sublingual tablets stored together with artificial tear drops. LVN 9 acknowledged and verified the findings. 2. a. On 8/13/25 at 1405 hours, an inspection of Medication Cart B and concurrent interview was conducted with LVNs 1 and 10, and the Clinical Consultant. During the inspection of Medication Cart (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B, the following was identified: - several bacitracin zinc ointment strips with expiration date of 5/25/25. - two normal saline 0.9% chloride 100 ml bottles labeled sterile when unopened were found opened and undated. LVNs 1 and 10, and the Clinical Consultant acknowledged and verified the findings. b. On 8/13/25 at 1445 hours, an inspection of Medication Cart C and concurrent interview was conducted with RN 2. During the inspection of Medication Cart C, the following was identified: - a package of rolled gauze bandage was opened. - a package of dressing change kit with chloraprep 3 ml was opened RN 2 acknowledged and verified the findings. On 8/14/225 at 0856 hours, a follow-up interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. On 8/12/25 at 0916 and 0930 hours, during the initial tour of the facility, Resident 2 was observed in bed, and a tube of Voltaren gel (NSAID medication) was observed at bedside. Resident 2 stated he used it on his knees. On 8/12/25 at 0955 hours, an observation for Resident 2 and concurrent interview was conducted with LVN 16. LVN 16 verified a tube of Voltaren gel was at Resident 2's bedside. LVN 16 stated the Voltaren gel was supposed to be applied by the treatment nurse. LVN 16 stated the family might have brought it. Medical record review for Resident 2 was initiated on 8/12/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Order Summary Report failed to show a physician's order for the Voltaren gel. 4. On 8/12/25 at 1000 and 1005 hours, during the initial tour of the facility, Resident 97 was observed in bed. A bottle of Refresh eyedrops (artificial tears provide relief for dry, burning, irritated eyes), a bottle of dry mouth spray, a tube of Triad hydrophilic wound dressing (treatment for light to moderate level of wound exudate), and a bottle of saline nasal spray were observed at bedside. On 8/12/25 at 1006 hours, an observation for Resident 97 and concurrent interview was conducted with LVN 16. LVN 16 verified a bottle of Refresh eyedrops, a bottle of dry mouth spray, a tube of Triad hydrophilic wound dressing, and a bottle of saline nasal spray were at bedside. LVN 16 stated the family might have brought the medications for the resident. Medical record review for Resident 97 was initiated on 8/12/25. Resident 97 was admitted to the facility on [DATE]. Review of Resident 97's Order Summary Report failed to show for the physician's orders for Refresh (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eyedrops, dry mouth spray, hydrophilic wound dressing and saline nasal spray. 5. On 8/12/25 at 0907 and 0910 hours, during the initial tour of the facility, Resident 23 was observed in bed, and a container of zinc oxide (skin barrier ointment) was observed at bedside. On 8/12/25 at 0953 hours, an observation for Resident 23 and concurrent interview was conducted with LVN 16. LVN 16 verified a container of zinc oxide cream was at the bedside. LVN 16 stated the zinc oxide cream was supposed to be applied by the treatment nurse and should not be left at bedside. LVN 16 stated the family might have brought the zinc oxide medication. Medical record review for Resident 23 was initiated on 8/12/25. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report failed to show a physician's order for the zinc oxide cream. 6. On 8/12/25 at 0907 and 0910 hours, during the initial tour of the facility, Resident 25 was observed in bed, and a bottle of Refresh eyedrops was observed at bedside. On 8/12/25 at 0952 hours, an observation for Resident 25 and concurrent interview was conducted with LVN 16. LVN 16 verified a bottle of Refresh eyedrops was at bedside. LVN 16 stated the family might have brought it. Medical record review for Resident 25 was initiated on 8/12/25. Resident 25 was readmitted to the facility on [DATE]. Review of Resident 25's Order Summary Report failed to show a physician's order for the Refresh eyedrops. On 8/18/25 at 1521 hours, an interview was conducted with the DON. The DON stated medications should not be left at bedside. The DON stated when the family brought a medications for the resident, and the resident requested to apply or administer their own medications, the resident should be assessed, and a physician's order will be obtained. 7. On 8/12/25 at 1000 hours, during the initial tour of the facility, Resident 138 was observed awake and lying supine in the bed. Resident 138 stated he could not turn or get out of the bed by himself and needed someone to clean him. An orange tube labeled Remedy zinc oxide paste skin protectant was observed on top of the overbed table at the left side of Resident 138's bed. Resident 138 stated he was not sure if the medication was being used for him. Medical record review for Resident 138 was initiated on 8/12/25. Resident 138 was admitted to the facility on [DATE]. Review of Resident 138's H&P examination dated 7/14/25, showed Resident 138 had fluctuating capacity but could make needs known. Review of Resident 138's Order Summary Report showed a physician's order dated 8/12/25, to cleanse coccyx Stage 1 pressure injury with normal saline, apply zinc oxide cream, and cover with foam dressing daily and as needed if soiled or dislodged every shift daily for 30 days. (continued on next page)

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Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/12/25 at 1015 hours, an interview for Resident 138 was conducted with LVN 7. LVN 7 stated the zinc oxide tube was from the resident's family members who came every day and applied it to Resident 138. LVN 7 stated the treatment nurse was the one responsible for applying the zinc oxide cream to the residents. LVN 7 stated no family member had come this morning yet when asked if there was a family member who came this morning already. LVN 7 stated he already administered the medications for Resident 138, and he might have missed seeing the zinc oxide cream at the overbed table. LVN 7 further stated if there was a medication left by the resident's family member at the bedside, the CNAs or nurses should have taken it and stored it properly in the medication cart when they found or saw it at the bedside. LVN 7 stated only moisturizing cream should be left at the resident's bedside. On 8/19/25 at 1436 hours, an interview was conducted with the DON. The DON stated no medications should be left at the bedside unless the resident had passed the self-administration assessment and with the physician's order. The DON further stated the cream with zinc oxide should not be left at the bedside. The DON was informed and acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the clear plastic trays were air dried prior to storing and stacking. These failures had the potential for cross contamination and foodborne illnesses to the residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 8/12/25, showed 88 of 140 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Hoods and Filters revised date 8/31/18, showed the hoods must be kept free of grease and dust at all times because of potentially high fire hazard. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention. The dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 8/12/25 at 0825 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS (Dietary Services Supervisor). The kitchen hood over the stove had black, dirt residue. The DSS acknowledged the findings. The DSS stated the dietary staff cleaned the hood weekly and was last cleaned by an outside company on 5/12/25. 2. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed chipped or cracked dishes trays shall be discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 8/12/25 at 0825 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS:- Two deformed stainless steel whisks.- Eight rubber spatulas with red handles were chipped and cracked at the edges.- Two stainless steel scoops for food portioning with gray handles were worn out and peeling. The DSS acknowledged the above findings and stated worn out utensils should have been replaced and discarded. 3. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed the dishes, trays, and utensils shall be routinely checked for stains or spots. Any dish, tray, or utensil with debris should not be used. Send back to the dish room to be properly washed and sanitized. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood-contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2017, 4-602.13, Non- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 8/12/25 at 0825 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed and verified by the DSS:- One stainless steel whisk was observed with white thread-like residue.- One rubber spatula (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with red handle was dirty and had dry yellow residue. - One white portable can opener was dirty with dry white, crusted residue on the blade.- One stainless steel slotted scoop with a yellow handle was fuzzy with cloudy film.- One stainless steel scoop for food portioning with cream handle had dry white, crusted residue.- One stainless steel scoop for food portioning with a green handle had dry thread-like residue.- One stainless steel scoop for food portioning with a red handle had dry, crusted residue and cloudy film. The DSS acknowledged the above findings and stated all the dirty and crusted kitchen utensils should have been rewashed for infection control purposes. 4. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20 showed cutting boards need to be washed and sanitized between each use. Replace cutting boards once lined with knife marks and they are unsanitizeable. Color-coded cutting boards are desirable designating boards for raw products versus cooked products. According to the USDA Food Code 2022, Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 8/12/25 at 0825 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The green, brown, blue, red, white, and yellow cutting boards were observed fuzzy, heavily marred, and had deep groves. The DSS verified the findings and stated the cutting boards were ordered monthly and should have been replaced. 5. Review of the facility's P&P titled Dry Storage- Dishes and Utensils revised 2/1/12, showed the dishes must be stored to promote air drying i.e. use dish racks or trays with plastic mesh that allow air to circulate, and air dry the dishes. Review of the facility's P&P titled Dish and Utensil Procedure revised date 3/3/20, showed the dishes, trays, and utensils shall be air dried before storage. Do not towel dry. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 8/12/25 at 0825 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. Two clear plastic trays were observed wet with visible water inside and stacked on top of each other. The DSS verified the findings and stated all the kitchen utensils and equipment should have been air dried to prevent bacteria growth.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain proper infection control practices. * The facility failed to accurately identify HAI in the monthly surveillance report. * The facility failed to ensure the residents' clothing and blankets from the laundry were handled in a sanitary manner. The spring lift inside a blue basket truck was observed with ripped edges, and when lifted, the bottom of the basket was pieces of paper, dryer sheets, towel and a sock. In addition, the AC filters of the AC in the clean area, and the AC near the folding area were observed dusty * The facility failed to ensure CNA 7 did not use the same pair of gloves and gown when providing care to Resident 1 on EBP (Enhanced Barrier Precaution) and then to Resident 159 who was not on EBP. * The facility failed to ensure CNA 2 practiced EBP when CNA 2 failed to don (put on) a gown prior to assisting Resident 111 with repositioning. * The facility failed to ensure infection control practices were observed when LVN 6 failed to disinfect the call light picked up from the floor mat prior to giving it to Resident 19. * The facility failed to ensure the phlebotomist technician wore proper PPE (Personal Protective Equipment) in an EBP room when performing a blood draw for Resident 39. *The facility failed to ensure LVN 7 disinfected the blood pressure cuff before use and perform hand hygiene before resident care for Resident 138. *The facility failed to ensure LVN 8 removed their gloves, perform hand hygiene, and apply clean gloves after closing Resident 31 and 85's curtain, before proceeding with resident care. These failures had the potential for the facility to not accurately identify, investigate, and prevent new infections from developing within the facility, and posed the risk of cross-contamination and spread of infection.Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised 12/19/22, showed the following: - A system of surveillance is utilized for prevention, 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 a facility assessment and accepted national standards; and -Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection. On 8/15/25 at 1011 hours, an interview, medical record review, and concurrent facility document review was conducted with the IP. The IP was asked to show the facility's infection control surveillance program for June and July 2025. The following was identified: a. Review of the facility's Infection Surveillance Monthly Report for June 2025 under the Urinary Tract/ Kidney Infections Category, showed there were five HAIs in the facility. When asked to identify which residents were classified as HAIs, the IP identified Residents 7, 8, 93, 126, 160, and 161. The IP verified she identified six residents, however, the surveillance report showed only five residents. b. Review of the facility's Infection Surveillance Monthly Report for July 2025 showed the following: - under the Blood/Systemic Infection Category, there was one HAI in the facility. When asked to identify the residents who were classified as HAIs, the IP identified Residents 126 and 160. The IP verified she identified two residents. However, the surveillance report showed only one resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- under the Other Infections Category, there were three HAIs in the facility. When asked to identify the residents who were classified as HAIs, the IP identified Residents 1, 7, and 9. The IP verified she identified three residents. However, the surveillance report showed two residents. - under the Urinary Tract/ Kidney Infections Category, there were two HAIs in the facility. When asked to identify the residents who were classified as HAIs, the IP identified Residents 4, 15, and 73. The IP verified she identified three residents. However, the surveillance report showed two residents. The IP verified the above findings. The IP stated the screening system did not pick up when she indicated the residents were in-house or HAI. The IP stated the resident information she entered on the infection screening in Point Click Care (a software used for electronic health records to reorder the medication). would automatically populate the Monthly Quality Assurance Report which would be presented to the Infection Control Committee meeting. 2. On 8/13/25 at 1431 hours, an inspection of the laundry area and concurrent interview was conducted with the Maintenance Director. The following was observed inside the laundry area: - A blue basket truck with a spring lift was observed near the dryers. The spring lift was observed with ripped edges exposing the rusty steel. When the spring lift was lifted, the bottom of the basket truck was observed with pieces of paper, dryer sheets, a towel and a single sock; and - The AC filters in the clean area and folding area were observed dusty. The Maintenance Director verified the above findings. The Maintenance Director stated the blue basket truck with a spring lift was used to transport washed clothes from the washers to the dryers. The Maintenance Director stated the blue basket truck should be cleaned daily, and the spring lift should have been replaced. The Maintenance Director stated the AC filters should be cleaned daily. 3. According to CDC's The Basics of Standards Precautions (undated), wear a gown when contact between clothing or skin with resident blood or body substances is expected, and to not wear the same gown between residents. Review of the facility's EBP sign showed everyone must clean hands, including before entering and when leaving the room, and the providers and staff also wear gloves and gown for the high contact resident care activities: ADL care, caring for the devices, toileting and changing incontinence briefs, wound care, mobility assistance, transferring and preparing to leave room, and cleaning environment. On 8/13/25 at 1250 hours, an EBP sign was observed posted outside Room A, and a blue dot was observed by Resident 1's name by the door. The following was observed: - CNA 7 was inside the room wearing gloves and a gown. Resident 1 was awake and in bed. CNA 7 assisted Resident 1 with his lunch tray. Without removing the gown and gloves used for Resident 1, CNA 7 went to Resident 159 and touched the resident's cup, and emptied Resident 159's urinal. CNA 7 doffed (took off) his gloves, washed his hands, and donned clean gloves. Without removing his gown used for Resident 1, CNA 7 (with a pair of new, clean gloves) assisted Resident 159 with his lunch tray. On 8/14/25 at 1033 hours, an interview was conducted with CNA 7. CNA 7 verified the above findings. CNA 7 acknowledged he used the same gown and gloves for Residents 1 and 159. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/15/22 at 1011 hours, an interview was conducted with the IP. The IP stated the blue dot by the resident's name meant the resident in the room was on EBP. The IP stated the staff cannot wear the same gown and gloves in caring for different residents. 4. According to the CDC, EBP are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. The EBP involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition. Review of the facility's signage for EBP showed everyone must clean their hands, including before entering and when leaving the room. It also showed providers and staff must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/ showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, and wound care: any skin opening requiring a dressing. Review of the facility's P&P titled Infection Prevention and Control Program date revised 12/19/22, showed the facility has established and maintains 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 as per accepted national standards and guidelines. All the staff are responsible for following all policies and procedures related to the program. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. All staff shall use PPE according to established facility policy governing the use of PPE. On 8/12/25 at 1108 hours, an observation and concurrent interview was conducted with CNA 2. Resident 111's room had an EBP sign posted by the door. CNA 2 was assisting another staff to reposition Resident 111. CNA 2 was only wearing the surgical mask and gloves but did not wear a gown. CNA 2 verified the above findings. CNA 2 verified Resident 111 was on the EBP for his wound. CNA 2 stated he should have worn the gown to prevent cross contamination. Medical record review for Resident 111 was initiated on 8/12/25. Resident 111 was admitted to the facility on [DATE]. Review of Resident 111's Order Summary Report for August 2025 showed a physician's order dated 8/6/25, for EBP related to wounds. On 8/12/25 at 1121 hours, LVN 5 was informed of the findings and stated CNA 2 should have worn the gown for infection control purposes. On 8/14/25 at 1347 hours, RN 1 was informed of the findings and stated the PPE required for EBP are gown and gloves. RN 1 further stated CNA 2 should have worn the gown for infection control purposes. 5. Review of the facility's P&P titled Infection Prevention and Control Program date revised 12/19/22, showed environmental cleaning and disinfection shall be performed according to facility policy. All the staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department. All reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with our current procedures (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	governing the cleaning and sterilization of soiled or contaminated equipment. On 8/14/25 at 0737 hours, an observation and concurrent interview was conducted with LVN 6. Resident 19's room was observed with an EBP sign posted by the door. Resident 19's bed remote control and call light were on the floor mat. LVN 6 picked up the call light and clipped it to Resident 19's bed sheet without disinfecting it. LVN 6 verified the above findings and stated the call light should have been disinfected for infection control purposes. Medical record review for Resident 19 was initiated on 8/12/25. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report for August 2025 showed a physician's order dated 5/9/25, for EBP related to wounds. On 8/14/25 at 1317 hours, during an interview, RN 1 was informed of the findings and stated the call light should have been disinfected prior to giving it to Resident 19 for infection control purposes. 6. Medical record review for Resident 39 was initiated on 8/14/25. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 7/18/25, showed the resident had the capacity to understand and make decisions. Review of Resident 39's Order Summary Report for August 2025 showed a physician's order dated 7/17/25, for EBP related to dialysis access site (permcath). Review of Resident 39's care plan for EBP related to dialysis access site dated 7/18/25, showed an intervention to apply EBP to prevent the spread of infections for specific care activities such as morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, mobility assistance and preparing to leave the room and cleaning and disinfecting the environment. On 8/14/25 at 0545 hours, an observation and concurrent interview was conducted with LVN 13 in front of room [ROOM NUMBER]. Phlebotomist Technician 1 was observed in room [ROOM NUMBER] attempting to get blood drawn for Resident 39 without a gown. Phlebotomist Technician 1's clothing was observed touching Resident 39's bedsheets and resident. An observation outside room [ROOM NUMBER] showed an EBP signage posted. LVN 13 verified above findings. LVN 13 stated Resident 39 is on hemodialysis and on EBP. LVN 13 stated residents with open wounds, dialysis, GT, and catheters are placed on EBP. LVN 13 stated Phlebotomist Technician 1 should have worn a gown and proper PPE to maintain infection control. On 8/14/25 at 0553 hours, an interview with Phlebotomist Technician 1 was conducted outside room [ROOM NUMBER]. Phlebotomist Technician 1 verified her clothing touched Resident 39 and his linen while attempting to do a blood draw. Phlebotomist Technician 1 verified she did not wear a gown and stated she did not know Resident 39 was on EBP. Moreover, Phlebotomist Technician 1 verified the isolation cart and the EBP sign were outside Resident 39's room. Phlebotomist Technician 1 stated she should have worn the proper PPE when working with residents in EBP to ensure infection control. On 8/19/25 at 1008 hours, an interview was conducted with the DON. The DON stated she expected (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the staff, family, and ancillary staff including phlebotomist and X-ray technicians to wear proper PPE when working with residents in an EBP room to prevent contamination and transfer of infections to other residents. The DON was informed and acknowledged the above findings. 7. Review of the facility's P&P titled Infection Prevention and Control Program revised 12/19/22, showed under staff education, all the staff shall demonstrate competence in relevant infection control practices. Direct care staff shall demonstrate competence in resident care procedures established by our facility. On 8/12/25 at 0818 hours, an observation for Resident 138 was conducted with LVN 7. LVN 7 placed a BP cuff on Resident 138. LVN 7 did not perform hand hygiene and disinfect the BP cuff before using it on the resident. On 8/12/25 at 1505 hours, an interview was conducted with LVN 7. LVN 7 verified the above findings. 8. On 8/12/25 at 1128 hours, an observation for Residents 31 and 85 was conducted with LVN 8. LVN 8 closed both Resident 31 and 85's curtains while wearing a pair of gloves. LVN 8 proceeded to provide resident care to the residents. LVN 8 did not perform hand hygiene and put on a new pair of gloves before providing patient care. On 8/12/25 at 1525 hours, an interview was conducted with LVN 8. LVN 8 verified the above findings. LVN 8 stated should have removed the gloves after closing the curtain for Residents 31 and 85, performed hand hygiene, and applied clean gloves before continuing with resident care. On 8/13/25 at 0938 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0755 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review and facility P&P review, the facility failed to implement their P&P related to the pharmaceutical procedures. * The facility failed to ensure the morphine (a controlled medication which has potential for abuse or dependence and under strict government control) medication was documented as administered to the resident when it was signed out on the Controlled Drug Record (CDR) for one nonsampled resident (Resident 15). This failure had the potential for Resident 15 to be exposed to the medication errors and diversion of the controlled medications. * The facility failed to ensure there were two nurse signatures on the Medication Disposition Record Log of the non-controlled drugs for multiple medications. This failure had the potential for diversion of the non-controlled medications.Findings: 1. Review of the facility's P&P titled Controlled Medications dated April 2008 showed when a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) Date and time of administration 2) Amount administered 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. 4) Initials of the nurse administering the dose on the MAR after the medication is administered. Medical record review for Resident 15 was initiated on 8/12/25. Resident 15 was readmitted to the facility on [DATE]. Review of Resident 15's Order Summary report showed a physician's order dated 8/7/25, to administer morphine sulfate oral tablet 15 mg, give one tablet by mouth every six hours as needed for severe pain. Review of Resident 15's Controlled Drug Record showed Morphine Sul IR 30mg tab give 0.5 (15 mg) tablet was removed/taken out on the following dates and times:- On 7/31/25 at 0630 and 0600 hours, and- On 8/1/25 at 0600 hours, and- On 8/3/25 at 0200 hours, and- On 8/7/25 at 1430 hours. Review of Resident 15's MAR for August 2025 failed to show documented evidence the morphine medication was administered to the resident on the above dates and times. On 8/13/25 at 1146 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 15's MAR for August 2025 did not match the Controlled Drug Record. On 8/14/25 at 0938 hours, an interview was conducted with the DON. The DON stated the medical records department audits the MAR for residents receiving controlled drugs on a weekly basis. The DON verified and confirmed the above findings. 2. Review of the facility's Medication Disposition Record/Pass log (undated) showed there were 31 non-controlled medications disposed and signed off by one nurse. On 8/13/25 at 1018 hours, an interview and concurrent facility document review was conducted with the MDS Coordinator. The MDS Coordinator confirmed the process for disposing non-controlled medications required two nurses and their signatures to dispose of the medications. The MDS Coordinator verified there was only one nurse signature on the log. On 8/14/25 at 0938 hours, an interview was conducted with the DON. The DON verified and confirmed the Medication Disposition Record/Pass log should have two nurses sign when disposing non-controlled medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	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)
F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and facility document review, the facility failed to ensure the Facility Assessment addressed or included the following: 1. Active involvement of required individuals in developing the Facility Assessment;2. A plan to maximize recruitment and retention of direct care staff; and3. A contingency plan for staffing needs. These failures had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and include the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's assessment dated [DATE], did not show the direct care staff member, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment; a plan to maximize recruitment and retention of the direct care staff; and a contingency plan for staffing needs. On 8/14/25 at 0755 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the Administrator. The Administrator verified the Facility Assessment review was dated 10/29/24, and verified there were no direct care staff, direct care representatives, residents' representatives, and family members actively involved in developing the Facility Assessment. The Administrator further verified there was no documentation of a plan to maximize recruitment and a contingency plan for staffing needs in the Facility Assessment. The Administrator stated he was aware of the current guidance. The Administrator verified and acknowledged the Facility Assessment was not updated based on the latest guidance from the CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055121	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Ridge Post Acute	466 Flagship Road Newport Beach, CA 92663

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical record was complete for one of 28 final sampled residents (Resident 8). *The facility failed to ensure Resident 8's information on the POLST (Physician Orders for Life-Sustaining Treatment) was filled out. This failure had the potential for the resident's care needs to not be met as their medical information was inaccurate. Findings: Medical record review for Resident 8 was initiated on 8/13/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's POLST dated 7/16/25, failed to show Section D - Information and Signatures was filled out. On 8/13/25 at 1457 hours, an interview and concurrent medical record review was conducted with the SSD. The SSD verified Section D of Resident 8's POLST was not completed. The SSD stated the resident has a copy of the advanced directive in the electronic chart. The SSD stated it was important to have the POLST filled out, so the staff knew how to follow and care for the resident properly. On 8/19/25 at 1142 hours, an interview was conducted with the DON. The DON was informed and verified the above findings.