STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055298	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fallbrook Skilled Nursing	325 Potter Street Fallbrook, CA 92028

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22 CCR S 72313S 72313. Nursing Service--Administration of Medications and Treatments(a) Medications and treatments shall be administered as follows:(1) No medication or treatment shall be administered except on the order of a person lawfully authorized to give such order.(2) Medications and treatments shall be administered as prescribed.(3) Tests and taking of vital signs, upon which administration of medications or treatments are conditioned, shall be performed as required and the results recorded.(4) Preparation of doses for more than one scheduled administration time shall not be permitted.Based on interview and record review, the facility failed to ensure 3 of 4 residents reviewed for omitted medication doses, (Residents 1, 3, and 4) and this failure placed the residents at risk of harm due to uncontrolled high blood presure. Findings:Resident 1 was admitted to the facility on [DATE], with diagnosis (health problems) that included Type 2 diabetes (a disorder of hormone secretion, that causes high blood sugar levels and complications such as kidney failure, circulatory problems, and vision problems); essential hypertension (High blood pressure, which contributes to strokes, heart disease, and kidney disease); and end stage kidney disease (a complication of diabetes and high blood pressure, where kidneys no longer function, leading to a build up of waste products and fluid in the body); and dependence on dialysis (a procedure where blood is artificially filtered by machines that take over the function of the kidneys).Resident 3 was admitted to the facility on [DATE], with diagnosis that included: End stage renal disease, dependence on dialysis, Type 2 diabetes, and essential hypertension,Resident 4 was admitted to the facility on [DATE], with diagnosis that included: end stage renal disease; dependence on dialysis; type 2 diabetes; essential hypertension.An interview was conducted with Resident 1 on 9/18/25 at 10:55 A.M. Resident 1 stated there were many problems here with medication, he does not recieve his medications regularly when he is out at dialysis. The nurses are nice, but not good with the medicines.On 9/18/25 at 11:45 A.M., a simultaneous interview with the Director of Nursing (DON) and review of Resphysician orders, and medication administration records for Residents 1, 3, and 4. Resident 1 orders included: an informative order that Resident 1 had dialysis on Tuesdays, Thursdays, and Saturdays every week, with a check in time of 9:45 A.M, and a medication order for Hydraliazine Hcl (a medication for high blood pressure), 25mg tablet, take 1 tablet by mouth three times a day for high blood pressure, and hold (do not give) if the SBP (systolic blood pressure-the top number in a blood pressure reading) is less than 110.For the month of August, there were 93 opportunities for this medication to be given. Scheduled times are 9 A.M., 1 P.M. and 5 P.M. The medication was not given for 14 opportunities, once at the 9 A.M. time, 11 times at the 1 P.M. time frame, and 1 time at the 5 P.M. time frame. The reasons documented for not giving the medication were absent without meds 1 time; Hold - see notes 1 time; and Other see notes 12 times. The notes were reviewed, and stated resdent was at dialysis - the 1 P.M. missed medications occurred on the Tuesday, Thursday and Saturday of Resident 1's dialysis days.Resident 1 also had a physicians order for Calcium Acetate (a calcium supplement) 667mg, give two tablets three times a day, at 7 A.M., 1 P.M., and 5 P.M.For the month of August 2025, there were 93 opportunities for this medication to be given. 12 times the medication was not given, with a reason - see progress notes, which reflected Resident 1 was at dialyis. Resident 3 physician orders included an informational order that resident 3 went to dialysis on Tuesdays, Thursdays, and Saturdays, with a pick up time of 1:30 P.M., and a return time of 6:45 P.M; and medication orders for: Hydralazine (a medication for high blood pressure) 100mg two times a day at 9 A.M., and 5 P.M.In August 2025, there were 62 opportunites for this medication to be given; 24 opportunities were missed, the medication was not given. The reasons documented were hold - see progress notes and Other-see progress notes with 3 reasons as hospitalized . The missed doses were Tuesday, Thursday and Saturday, 15 times at the 5 P.M. time, and 8 times at the 9:00 AM times. One dose was marked NA, but checked as given on Friday, 8/23/25. On six days, (Aug. 2, 12, 14,16, 21, and 26) Residnet 3 did not receive any of this medication.Resident 3 also has a physician order, dated 1/20/25, for Carvedilol (a medication for both high blood pressure or an irregular heart beat), 25mg orally twice a day for high blood pressure with directions to hold (not give) if Resident 3's blood pressure was less than 100 or his heart rate was less than 60. Out of 62 opportunities for this medication to be given, it was omitted 17 times, with reasons documented as other/hold - see progress notes 15 times; in hospital three times; and vitals outside of parameter one time.Resident 4 physician orders included: an informational order that resident went to dialysis on Tuesdays, Thursdays, and Saturdays, and pick up time was 1 P.M. No return time was

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22 CCR S 72543S 72543. Patients' Health Recordsa) Records shall be permanent, either typewritten or legibly written in ink, be capable of being photocopied and shall be kept on all patients admitted or accepted for care. All health records of discharged patients shall be completed and filed within 30 days after discharge date and such records shall be kept for a minimum of 7 years, except for minors whose records shall be kept at least until 1 year after the minor has reached the age of 18 years, but in no case less than 7 years. All exposed X-ray film shall be retained for seven years. All required records, either originals or accurate reproductions thereof, shall be maintained in such form as to be legible and readily available upon the request of the attending licensed healthcare practitioner acting within the scope of his or her professional licensure, the facility staff or any authorized officer, agent, or employee of either, or any other person authorized by law to make such request.(b) Information contained in the health records shall be confidential and shall be disclosed only to authorized persons in accordance with federal, state and local laws. (f) Patients' health records shall be current and kept in detail consistent with good medical and professional practice based on the service provided to each patient. Such records shall be filed and maintained in accordance with these requirements and shall be available for review by the Department. All entries in the health record shall be authenticated with the date, name, and title of the persons making the entry.(g) All current clinical information pertaining to a patient's stay shall be centralized in the patient's health record. Based on interview and record review, the facility staff failed to maintain accurate and complete health records for two of four residents (Residents 3, 4) reviewed for medication administration. This failure had the potential for resident harm by not presenting a full and accurate record of the resident's status, and potentially missing a change in health. Findings:Resident 3 was admitted to the facility on [DATE], with diagnosis that included: Type 2 diabetes (a disorder of hormone secretion, that causes high blood sugar levels and complications such as kidney failure, circulatory problems, and vision problems); essential hypertension (High blood pressure, which contributes to strokes, heart disease, and kidney disease); and end stage kidney disease (a complication of diabetes and high blood pressure, where kidneys no longer function, leading to a build up of waste products and fluid in the body); and dependence on dialysis (a procedure where blood is artificially filtered by machines that take over the function of the kidneys).Resident 4 was admitted to the facility on [DATE], with diagnosis that included: Type 2 diabetes (a disorder of hormone secretion, that causes high blood sugar levels and complications such as kidney failure, circulatory problems, and vision problems); essential hypertension (High blood pressure, which contributes to strokes, heart disease, and kidney disease); and end stage kidney disease (a complication of diabetes and high blood pressure, where kidneys no longer function, leading to a build up of waste products and fluid in the body); and dependence on dialysis (a procedure where blood is artificially filtered by machines that take over the function of the kidneys).On 9/18/25 at 11:45 A.M. a review of the physician orders, and medication administration records for Residents 3 and 4 was conducted with the Director of Nursing (DON).Resident 3 had a physician order, dated 1/20/25, for Carvedilol (a medication for both high blood pressure or an irregular heart beat), 25mg orally twice a day for high blood pressure with directions to hold (not give) if Resident 3's blood pressure was less than 100 or his heart rate was less than 60. Out of 62 opportunities for this medication to be given, it was omitted 17 times, with reasons documented as other/hold - see progress notes 15 times; in hospital three times; and vitals outside of parameter one time. For the Vitals outside of parameters, there is no documentation of Resident 3's blood pressure or heart rate.Resident 4 had medication orders including: Isosorbide Mononitrate ER 60mg (a blood pressure medication) give once daily for hypertension, hold if blood pressure less than 100 or heart rate (beats per minute) less than 60. Out of 31 opportunities, the record is blank for August 1, the medication was not given due to Resident 4 refusing three times, and was held as outside of parameters once. The blood pressure and heart rate were not documented on the refusals, only an N/A. The medication was given in error on August 10, 2025 when Resident 4's heart rate was below 60 (58). Resident 4 medication order of Glargine Insulin (a long acting medication used to lower blood sugar), dated 9/4/2024, of 8 units subcutaneously (under the skin) daily had 31 opportunities to be given in August 2025. 22 opportunities the insulin was not given, with a notation resident refused and twice the medication was not given for other-see note. On those 22 opportunities, the blood sugar value was not entered, with an N/A (not applicable) entered instead. Resident 4's medication order for Lispro insulin, dated 9/4/24 (a short acting medication to lower