STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure residents were treated with dignity and respect for one of seven residents (Resident 1) when two Certified Nurse Assistants (CNA 2, CNA 3) spoke loudly and disrespectfully to Resident 1 and accused her of taking her roommate's remote control and adjusting the television to face Resident 1.This failure placed Resident 1 at potential risk for emotional distress, depression, mental instability, and decline in overall health. During an interview on 11/25/25 at 9:38 a.m., Resident 1 reported two CNAs (CNA 2, CNA 3) accused her of turning her roommate's TV and taking the remote control. Resident 1 stated the CNAs spoke loudly and angrily, calling her a liar, which she found unprofessional and hurtful. During a review of Resident 1's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/25/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses: type 2 diabetes mellitus (DM2-- a condition where your body does not use a hormone that helps move sugar from your blood into your cells for energy properly), protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), other stimulant abuse, bipolar disorder (,a serious mental illness that causes unusual shifts in mood, ranging from extreme highs (mania or manic episodes) to lows (depression or depressive episode)), major depressive disorder (persistent feeling of sadness and loss of interest), post-traumatic stress disorder (extreme fear during or after witnessing or experiencing potentially traumatic events, such as war, accidents, natural disasters or sexual violence), chronic pain syndrome. During a review of Resident 1's Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 9/17/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function (a mental process such as memory, language, or problem-solving that helps someone to think and process information) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment. During an interview on 11/25/25 at 10:46 a.m. with CNA 1, CNA 1 stated staff should not yell at residents to preserve their dignity. CNA 1 stated residents deserve to be treated with respect and yelling could make them feel belittled or depressed. During an interview on 11/25/25 at 11:54 a.m. with the Administrator (ADM), the ADM stated on 11/11/25 around 7:30 p.m., the Director of Staff Development (DSD) informed her two CNAs argued with Resident 1 and were immediately suspended. The ADM stated he interviewed alert residents who stated they heard arguing but could not identify who was involved. The ADM stated he interviewed Licensed Vocational Nurse (LVN 5), who witnessed the incident. The ADM stated LVN 5 reported CNA 2 and CNA 3 argued with Resident 1 and behaved inappropriately. The ADM stated CNA 2 and CNA 3 had final written warnings due to misconduct. The ADM stated CNA 2 and CNA 3 were terminated on 11/17/25.During an interview on 11/25/25, at 12:09 p.m. with the Registered Nurse (RN), the RN stated it was unacceptable for staff to yell at residents. The RN stated staff members must act appropriately and address the needs of the residents. The RN stated if a resident were to yell at staff, it would still be inappropriate for staff to respond by yelling at the resident. The RN stated the residents have a right to be treated with respect and dignity. During an interview on 11/25/25 at 1:45 p.m. with the Director of Nursing (DON), the DON stated staff must maintain residents' dignity and safety and should not raise their voices when speaking to residents. The DON stated raising one's voice when speaking to residents could cause emotional distress, lead residents to refuse food, or diminish their trust in staff. During a phone interview on 12/2/25, at 3:25 p.m. with CNA 2, CNA 2 stated Resident 1 took her roommate's television (TV) remote control and turned the TV away from her roommate's view to face herself. CNA 2 stated she and CNA 3 went to Resident 1's room, retrieved the remote, and redirected the television towards the roommate's view. CNA 2 stated Resident 1 told LVN 5 what happened and accused CNA 2 and CNA 3 of lying. CNA 2 stated they did not respond to the accusation. CNA 2 stated yelling at residents was never acceptable and all residents should be treated with dignity and respect. CNA 2 stated treating residents poorly could lead to depression or decline in residents' health. During a phone interview on 12/2/25 at 3:47 p.m. with CNA 3, CNA 3 stated she and CNA 2 entered Resident 1's room and found the roommate's TV positioned towards Resident 1. CNA 3 stated they repositioned the TV to face the roommate. CNA 3 stated while attending to the roommate's needs, Resident 1 yelled at her for moving the TV. CNA 3 stated she attempted to explain to Resident 1the need for privacy for the roommate, but Resident 1 continued arguing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to protect residents' rights and ensure they were free from misappropriation of property, medications were administered as prescribed, and controlled drugs were properly accounted for and discarded according to facility's policy and procedure for two of three sampled residents (Resident 5 and Resident 6) when License Vocational Nurse (LVN) 5 diverted controlled medications (drugs regulated by law for potential abuse, addiction, or dependence) prescribed for Resident 5 and Resident 6 for personal use and failed to properly document, discard discontinued medications according to facility's policies and procedures. These failures resulted in Resident 5 and Resident 6 not receiving their prescribed medications as ordered which placed them at risk for inadequate pain management and anxiety. During an interview on 11/25/25 at 12:09 p.m. with Registered Nurse (RN), the RN stated controlled substances were stored in the controlled substance drawer of the medication cart. The RN stated the facility had two medication carts; one located at each nursing station. Each medication cart had one controlled substance key which was maintained by the assigned Licensed Nurse (LN). The RN stated during shift change, two LNs would audit the controlled substances medications by reviewing the Controlled Substance Record (log used to document the actual pill count of controlled substance) and conduct a physical count of the total number of pills. The RN stated after verifying the record and count were accurate, both LNs signed the controlled substance records. The RN stated when a resident was discharged from the facility, the LN placed unused controlled substance medications in the discontinued section of the controlled substance drawer. The RN stated the LN was responsible for handing off discontinued controlled substances to the Director of Nursing (DON) when available. The RN stated upon transfer of discontinued controlled substances, the DON and the LN reviewed the discontinued controlled substance medication record, verified the total number of discontinued pills and both signed the controlled substance record after confirming the count was accurate. The RN stated if discrepancies were identified between the controlled substance record and the actual pill count, the LN would review the controlled substance record line items to identify the discrepancy. The RN stated if the discrepancy could not be resolved, the LN notifies the DON, Medical Director (MD), and the Administrator (ADM) for further investigation. During an interview on 11/25/25 at 12:40 p.m. with LVN 1, LVN 1 stated the LNs were responsible for managing and documenting controlled substances from the pharmacy through administration and discontinuation by physician order. LVN 1 stated controlled substances were stored in a secure medication cart, which included a separate locked drawer designated for controlled substances. LVN 1 stated only the nurse assigned to the nursing station-maintained possession of the key to the controlled substance drawer. LVN 1 stated when a controlled substance was administered, the LN signed the Controlled Drug Record, removed the bubble pack from the locked drawer, removed the prescribed dose, administered the medication to the resident, and documents the administration on the Medication Administration Record (MAR). LVN 1 stated the LN would verify the pill count and document on the Controlled Drug Record match the remaining quantity in the bubble packs. LVN 1 stated upon resident's discharged , all controlled drug substances should be delivered to the DON. LVN 1 stated licensed nurse give the controlled substance record and discontinued bubble packs to the DON for review and verification. LVN 1 stated after the pill count was verified, both the DON and the LN signed the controlled substance record, and the DON secured the discontinued controlled substance for destruction. LVN 1 stated if the DON was not available to receive discontinued controlled substances, the controlled substances were stored in the discontinued section of the controlled substance drawer inside the medication cart, and two LNs verified the controlled substance count at each change of shift until the DON was available for transfer. During a concurrent interview and record review on 11/25/25 at 1:45 p.m. with the DON, the facility's document titled Shift Change Controlled Substance Inventory Log, dated 11/14/25 was reviewed. The Shift Change Controlled Substance Inventory Log indicated Resident 5's oxycodone 5 mg quantity was zero. The DON stated Resident 5 was discharged home on [DATE]. The DON stated Resident 5's two bubble packs of Oxycodone (medication used to relieve pain) 5 mg (milligram- unit of measurement) remained in the controlled substance drawer after discharge. The DON stated on 11/14/25, LVN 5 documented on the Shift Change Controlled Substance Inventory Log (log used to document counts of controlled substance bubble packs) a count of zero for Resident 5's Oxycodone 5 mg, which indicated the bubble packs were emptied. The DON stated on 11/17/25, LVN 3 discovered Resident 5's two bubble packs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to maintain accurate controlled substance records, documentation and reconciliation in accordance with facility's policies and procedures for two of three sampled residents (Resident 5, 6) when the license nurses (LNs) failed to accurately document and account Resident 5 and Resident 6 controlled substance on the Controlled Drug Records and Medication Administration Record to accurately reflect the controlled substance disposition or resident administration. These failures resulted in the facility's delayed detection of controlled substances diversion for Residents 5 and 6, and placed residents at potential risk for medication errors, untreated pain, and overdose, compromising residents' safety and quality of care. During an interview on 11/25/25 at 12:09 p.m. with the Registered Nurse (RN), The RN stated when controlled substances were delivered, the licensed nurse (LN) checked the medications against the pharmacy manifest to ensure the resident name, medication name, dose, and instructions for use matched the physician's order. The RN stated after verifying, the LN and delivery person signed the manifest, which was filed at the nurse's station. The RN stated LNs recorded the received controlled substances on the Shift Change Control Substance Inventory Log. The RN stated each shift change, two LNs counted the pills in the narcotic drawer and compared them to the records. The RN stated if there was a discrepancy, the LN's reviewed documentation to identify and correct errors, and if it could not be resolved, the LNs notified the Director of Nursing (DON) and the Administrator (ADM). The RN's stated controlled substances required close monitoring because too much medication could cause drowsiness or overdose, placing residents at risk.During an interview on 11/25/25 at 1:45 p.m. with the DON, the DON stated when controlled substances were delivered to the facility, the pharmacy would deliver it directly to the LN. The DON stated the LN would verify with the delivery staff what was received, ensure the bubble packs were intact, and nothing was missing. The DON stated once the controlled substances were verified against the manifest, physician order and the bubble pack label, the LN and delivery staff would sign the manifest. The DON stated the LN would place the controlled substances in the double locked drawer of the medication cart. The DON stated the Controlled Drug Record was stored in a binder and the Shift Change Controlled Substance Inventory Log would be updated with the addition of the pharmacy delivery. The DON stated when the LN prepared to administer controlled substances, the LN should verify the count on the Controlled Drug Record and the bubble pack contents matched. The DON stated the LN should document the date, time and dose of the medication given on the Controlled Drug Record in the binder and in the MAR. The DON stated during shift change, the LN would verify the Shift Change Controlled Substance Inventory Log's recorded total sheets (bubble packs) at the end of the shift would match the number of bubble packs in the controlled substance drawer. The DON stated that LNs would compare the Controlled Drug Record's pill count with the number of pills in the bubble packs in the controlled substance drawer. During a review of Resident 5's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/25/25, the AR indicated Resident 5 admitted on [DATE], discharged [DATE] and had a history of muscle weakness, difficulty walking, alcoholic liver with ascites (a buildup of fluid in your abdomen causing a swollen belly), liver failure, encephalopathy (a disturbance of brain function that causes confusion, memory loss and coma in severe cases), Type 2 Diabetes Mellitus (a condition where your body does not use a hormone that helps move sugar from your blood into your cells for energy properly), alcoholic dependence and had spinal surgery on 9/7/25.During a review of Resident 5's Order Summary (OS) dated 9/23/25, the OS indicated oxycodone hydrocholoride (HCl) (drugs used to treat pain) Oral Tablet 5 mg Give 2 tablet by mouth every 4 hours as needed for severe pain.oxycodone HCl Oral Tablet 5 mg Give 1 tablet by mouth every 4 hours as needed for moderate pain.During a review of Resident 5's Controlled Drug Records dated 10/25/25, undated and 11/8/25, and the MAR dated [DATE], the Controlled Drug Record indicated Oxycodone HCL 5 mg Tablet Give 1 Tablet by mouth every 4 hours as needed for moderate pain, Give 2 tablets for severe pain. The MAR indicated Pain: monitor for presence of pain every shift using scale 0-10. 0=No pain, 1-3=mild pain, 4-6=moderate pain, 7-9=severe pain, 10 =very severe/horrible/worst pain .Oxycodone 2 tablets by mouth every 4 hours as needed for severe pain. The Controlled Drug Record indicated oxycodone HCL was removed from the controlled drug drawer on 11/3/25 at 9 p.m., 11/4/25 at 1:34 p.m., 4:43 p.m., 9:44 p.m., and 11/5/25 at 6 a.m., and 7:37 p.m., 11/6/25 at 4:10 a.m., 7:55 a.m., 3:27 p.m., and 7:55 p.m., and 11/7/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055454	A. Building B. Wing	12/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vineyards at Fowler	1306 East Sumner Avenue Fowler, CA 93625

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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews the facility failed to ensure residents were free from unnecessary medications administration for three of three sampled residents (Resident 1, 5, and 6) when license nurses (LN) assessed Resident 1, Resident 5, and Resident 6's pain levels as mild to moderate and administered pain medications prescribed for severe pain, not in accordance with the physician's order. These failures had the potential to place Resident 1, Resident 5, and Resident 6 at risk for over-medication, respiratory distress, impaired cognition, falls, and inadequate pain control. During a review of Resident 1's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/25/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which includes type 2 diabetes mellitus (DM2-- a condition where the body has trouble controlling blood sugar levels, causing blood sugar to become high) and chronic pain syndrome. During a review of Resident 1's Medication Administration Record (MAR), the MAR indicated physician order for Hydrocodone-Acetaminophen [medication used to treat pain] 5-325 mg [milligrams- unit of measurements] give 1 tablet by mouth every 8 hours as needed for moderate to severe pain and Tramadol [medication use to treat pain] HCL [hydrochloride] 50 mg give one tablet by mouth every 6 hours as needed for moderate to severe pain. The MAR indicated Resident 1 received Hydrocodone Acetaminophen 5/325 mg on 11/4/25 at 12:06 a.m. for a reported pain level 3 out of 10. Tramadol 50mg was administered on 11/4/25 at 9:38 p.m., 11/6/25 at 3:11 a.m., 11/7/25 at 8:30 a.m., 11/8/25 at 9:03 a.m., and 11/28/25 at 11;36 a.m., for a reported pain level of 3 out of 10. During a review of Resident 5's AR, dated 11/25/25, the AR indicated Resident 5 was admitted on [DATE], discharged [DATE]. Resident 5 had a history of muscle weakness, difficulty walking, alcoholic liver with ascites (a buildup of fluid in your abdomen causing a swollen belly), liver failure, encephalopathy (a disturbance of brain function that causes confusion, memory loss and coma in severe cases), and had spinal surgery on 9/7/25. During a review of Resident 5's Order Summary (OS) dated 9/23/25, the OS indicated oxycodone [medication used to treat pain] HCl Oral Tablet 5 mg Give 2 tablet by mouth every 4 hours as needed for severe pain.oxycodone HCl Oral Tablet 5 mg Give 1 tablet by mouth every 4 hours as needed for moderate pain. During a review of Resident 5's MAR dated [DATE], the MAR indicated Pain: monitor for presence of pain every shift using scale 0-10. 0=No pain, 1-3=mild pain, 4-6=moderate pain, 7-9=severe pain, 10 =very severe/horrible/worst pain. The MAR indicated oxycodone 2 tablets by mouth every 4 hours as needed for severe pain and was administered on 11/2/15 at 5:15 p.m., 11/3/25 at 1:56 a.m., 11/3/25 at 7:52 a.m., 11/3/25 at 12:44 p.m., 11/4/25 at 3 a.m., 11/4/25 at 8:04 a.m., 11/5/25 at 1:50 a.m., 11/6/25 at 12 a.m., and 11/7/25 at 4:34 a.m. for a reported pain level ranging from 3 out of 10 and 4 out of 10, indicating the pain oxycodone was given for pain below the physician ordered severity level. During a review of Resident 6's AR, dated 11/25/25, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included fracture (a partial or complete break in a bone) of unspecified bone in left wrist, , chronic pain syndrome, osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), age related osteoporosis (is a condition where the bones become weak and brittle, , making them easy to break), fracture of T9-T10 [ninth and tenth thoracic] vertebra (a broken bone in your mid-upper back), multiple rib fractures, fractured coccyx (broken tailbone), and a fracture of the distal left radius (broken wrist). During a review of Resident 6's MAR, the MAR indicated that Resident 6 was prescribed: Hydrocodone-Acetaminophen Oral Tablet 10-325 mg Give 1 tablet by mouth every 4 hours as needed for moderate to severe pain 4-10 start date 9/22/25 11:15 and discontinue [DC] date 11/21/25 16:49, and Hydrocodone-Acetaminophen Oral Tablet 10-325 mg Give 1 tablet by mouth every 4 hours as needed for severe pain 7-10 Start Date 11/22/25 14:27, and Hydrocodone-Acetaminophen Oral Tablet 10-325 mg Give 1 tablet by mouth two times a day for severe pain 7-10 for 10 days start date 11/25/25 16:00. The MAR indicated Resident 6 was administered: Hydrocodone-Acetaminophen 10/325 give 1 tablet every 4 hours as needed for moderate to severe pain 4-10 Start date 9/22/25 11:15, DC Date 11/21/25 16:49 on:o 11/12/25 5:26 a.m. for pain 3/10 Hydrocodone-Acetaminophen 10/325 give 1 tablet every 4 hours as needed for severe pain 7-10, Start date 11/22/25 14:27:o 11/24/25 09:37 for pain 6/10o 11/25/25 04:09 for pain 4/10o 11/25/25 08:25 for pain 6/10o 11/27/25 01:46 for pain 5/10o 11/28/25 03:47 for pain 3/10 o 12/6/25 16:58 for pain 5/10 During a phone interview on 12/2/25 at 2:15 p.m. with the Licensed Vocational Nurse (LVN) 3, LVN 3 stated PRN (pro re nata meaning as needed) pain medication orders are