| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055622 | A. Building<br>B. Wing | 08/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Bonita Hills Post Acute | 1233 West LA Habra Boulevard<br>LA Habra, CA 90631 |

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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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed in the kitchen when: * Pasteurized eggs were not available for one resident (Resident 62) who requested fried over easy eggs daily with breakfast. * Four fry pans were not clean and had excessively worn surfaces.* Three steam table pans were stacked and stored wet.* One food prep sink did not have a backflow prevention. * Four cereal bins were outdated. These failures had the potential to cause food borne illnesses in a highly susceptible resident population who received food prepared in the facility kitchen. Findings: Review of the facility's matrix dated 8/5/25, showed 62 residents were on an oral diet. 1. Review of the facility P&P titled Egg Cookery and Storage revised 5/2020 showed the food and nutrition department should ensure that eggs are prepared in a manner to preserve quality, maximize nutritional retention and to be free of salmonella. Do not use raw eggs as an ingredient in the preparation of uncooked, ready-to-eat menu items unless using pasteurized eggs. Pasteurized eggs should be substituted for such items as scrambled eggs, omelets, French toast. During the initial tour of the kitchen on 8/5/25 at 0820 hours, an observation of Refrigerator A and concurrent interview was conducted with the DSS. One opened case of shell eggs labeled SEFS (California Shell Egg Food Safety) Complaint eggs were observed. The DSS stated the shell eggs were used for fried egg requested by the residents. When asked if the SEFS eggs were pasteurized, the DSS stated the food purveyor told him the SEFS eggs were pasteurized. On 8/5/25 at 0956 hours, a follow-up interview was conducted with the DSS. The DSS provided the invoice for the shell eggs dated 7/21/25, which showed the shell eggs were not pasteurized. The DSS stated he would try to purchase pasteurized eggs from a different purveyor. On 8/5/25 at 1542 hours, an interview was conducted with the DSS and RD. The DSS shared an email from a purveyor which stated pasteurized eggs would be delivered to the facility on 8/6/25 at 0500 hours. The DSS stated there were residents who requested fried eggs every morning. Medical record review for Resident 62 was initiated on 8/5/25. Resident 62 was admitted to the facility on [DATE]. Review of Resident 62's physician's order dated 6/11/25, showed an order for a regular texture CCHO (carbohydrate controlled) diet. Review of Resident 62's breakfast meal ticket dated 8/6/25, showed Resident 62 preferred over easy fried eggs with breakfast. On 8/6/25 at 1052 hours, an interview was conducted with Resident 62. Resident 62 was alert and oriented. Resident 62 verified she preferred two over easy fried eggs every morning with breakfast. On 8/7/25 at 0930 hours, an interview was conducted with the RD. The RD was asked about her oversight of the kitchen. The RD stated the pasteurized eggs should always be available. When asked if the RD had checked to ensure pasteurized eggs were available as part of her monthly kitchen audit, she stated the pasteurized eggs were not included in the monthly audit of the kitchen. 2. According to the USDA Food Code 2022 Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces and Utensils A. Equipment, food-contact surfaces and utensils shall be clean to sight and touch. B. The food-contact surfaces of cooking equipment and pans shall be free of encrusted grease deposits and other soil accumulations. On 8/5/25 at 0820 hours, during the initial tour of the kitchen, an observation of<br>(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 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | multiple fry pans and concurrent interview was conducted with the DSS. Four fry pans were observed with a greasy, black residue and food debris on the cooking surfaces. The DSS verified the findings and stated he would replace the fry pans. 3. Review of the facility's P&P titled Dry Storage- Dishes and Utensils revised 2/1/12, showed the dishes must be stored and to promote air drying i.e. use dish racks or trays with plastic mesh that allow air to circulate, and air dry the dishes. On 8/5/25 at 0820 hours, during the initial tour of the kitchen, an observation of three small steamtable pans and concurrent interview was conducted with the DSS. Three small steamtable pans were observed stacked together with water residue between the pans. The DSS verified all the equipment should be air dried. 4. According to the USDA Food Code 2022 Section 5-402.11 Backflow Prevention (A) .A direct connection may not exist between the sewage system and a drain originating from equipment in which food, .is placed. On 8/5/25 at 0950 hours, an observation of a food preparation sink located next to the dish machine and concurrent interview was conducted with the Maintenance Director. The food preparation sink drainpipe was plumbed directly into the wall. When asked if the food preparation sink had an air gap, the Maintenance Director verified the food preparation sink had no air gap. 5. Review of the facility P&P titled Dry Storage Chart revised 4/6/22, showed dry cereal, once opened was good for two to three months at a temperature of 70 degrees Fahrenheit (F). On 8/5/25 at 0820 hours, during the initial tour of the kitchen, an observation of the dry storeroom and concurrent interview was conducted with the DSS. The thermometer located in the dry storeroom read 90 degrees F. Four plastic bins containing dry cereal were observed with a use by date of 8/1/25. The DSS stated the cereal was good for three months once opened. The DSS verified the findings and stated the cereal would be discarded. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide reasonable accommodations to meet the needs for one of six residents (nonsampled Resident 29) reviewed for resident council. * The facility failed to ensure Residents 29's call light was functioning properly. This failure had the potential to negatively impact Resident 29's psychosocial well-being or result in a delay to provide care.Findings: Review of the facility's P&P titled Call Lights: Accessibility and Timely Response dated 12/19/22, showed the facility is adequately equipped with a call light and the facility staff ensure the call light will be accessible to residents while in bed within the resident's room. On 8/6/25 at 1035 hours, a resident council meeting was conducted with the selected residents of the facility. Resident 29 attended the resident council meeting and expressed her concern about her call light not functioning. Resident 29 stated about two weeks ago, the facility were made aware about her call light not functioning and she was provided a call bell to use to call the facility staff when she needed assistance. Resident 29 stated she needed to wait a longer period of time for the nurses when she needed assistance. Medical record review for Resident 29 was initiated on 8/6/25. Resident 29 was admitted to the facility 5/24/25. Review of Resident 29's plan of care showed a care plan problem dated 8/3/23, addressing Resident 29's risk for falls. The interventions included to keep the call light within reach at all times. On 8/7/25 at 0848 hours, an observation and concurrent interview with Resident 29, LVN 3, and the Social Services Assistant was conducted. LVN 3 was in the hallway near Resident 29's room and stated Resident 29's bedroom door remained closed all the time because it was the residents' preference to have the door closed at all times. Resident 29 was observed in bed with the call bell on top of the over bed table in front of her. Resident 29 stated she was informed by the maintenance staff about her call light and there was a sound at the nurse's station but there was no light flashing on the panel to indicate her call light was turned on. Resident 29 tested her call light and pressed the red button. Resident 29's call light indicator above the door was not flashing and the call light indicator panel in the nurse's station was observed with an audible sound (beeping). However, there was no light indication to show what room call light was turned on to determine which room/resident needed assistance. During the interview with the Social Services Assistant who was at the nurse's station, the Social Services Assistant was asked which room had the call light on and needed assistance. The Social Services Assistant was unable to tell which room had the call light on and was observed going to the hallways and asking the other facility staff to ask their assigned residents who turned on their call light. The Surveyor returned to Resident 29's room and Resident 29 was asked how she felt about her call light not working. Resident 29 stated she was worried that if she needed urgent assistance, the facility staff might not come right away. Resident 29 stated the call bell did not work, specially when the door in her room was closed. Resident 29 added she needed to be turned and repositioned in the bed every two hours and sometimes she needed to remind and call the facility staff to reposition her in bed but sometimes the facility staff did not respond to her call bell right away. On 8/7/25 0859 hours, an observation and concurrent interview was conducted with CNA 6. CNA 6 was observed attending to Resident 29's need. CNA 6 was asked about the call light of the resident and stated she was aware Resident 29's call light was not working. CNA 6 stated she was made aware about two weeks ago, and she provided the call bell to the resident. On 8/7/25 at 0915 hours, an interview was conducted with the Maintenance Director. The Maintenance Director stated he was made aware about Resident 29's call light not functioning. The Maintenance Director stated the contracted company technician was at the facility and fixed the bulb on the call light panel and in the hallway, which were both working well. The Maintenance Director was informed about the observation about the call light of Resident 29. The Maintenance Director verified and acknowledged the call light of the resident was not functioning well. The Maintenance Director was asked to show the work order documentation regarding the resident's call light malfunction. The Maintenance Director verified and acknowledged<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | he was made aware about the call light problem verbally and there was documentation to show the work order for Resident 29's call light. 8/7/25 at 0924 hours, a follow up interview was conducted with the Maintenance Director. The Maintenance Director showed an email from the contracted company technician indicating the company was waiting for replacement parts to fix the call light for Resident 29. On 8/7/25 at 1355 hours, an interview was conducted with the Administrator. The Administrator acknowledged and verified he was aware about Resident 29's call light problem. The Administrator was asked on what other alternatives could be provided, while waiting for the parts for the call light system to be fixed besides providing the resident with a call bell in the room. The Administrator verified and acknowledged the IDT did not have any alternatives to provide for the resident besides the call bell, when she needed to call for assistance. The Administrator was asked about Resident 29's preferences for her bedroom door to be close at all times, and the ineffectiveness of the call bell when the bedroom door was closed. The Administrator verified and stated he was aware about Resident 29's preferences. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**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 clarify and follow up regarding the residents' rights to formulate the advance healthcare directives for two of six final sampled residents (Residents 28 and 85) reviewed for advance directive. * The facility failed to ensure Resident 28 and 85's information about advance directive were accurate. In addition, the facility failed to obtain a copy of Resident 28 and 85's advance directive to be placed in the residents' medical record. These failures had the potential for the residents' decisions regarding their healthcare and treatment options not being honored. Findings: Review of the facility's P&P titled Residents' Rights Regarding Treatment and Advance Directive dated 12/19/22, showed the following:- On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate an advance directive. Should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.- The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 1. Medical record review for Resident 28 was initiated on 8/5/25. Resident 28 was admitted to the facility on [DATE]. Review of Resident 28' s POLST ( Physician Orders for Life-Sustaining Treatment) dated 5/7/25, under section D Information and Signatures, showed Resident 28 had no advance directive. Review of Resident 28's Advance Directive Acknowledgement form date 5/5/25, showed Resident 28 had executed an advance directive. Further review of Resident 28's medical record failed to show documented evidence of Resident 28's copy of the advance directive. 2. Medical record review for Resident 85 was initiated on 8/5/25. Resident 85 was admitted to the facility on [DATE]. Review of Resident 85' s POLST dated 7/21/25, under section D Information and Signatures, showed Resident 85 had no advance directive. Review of Resident 85's Advance Directive Acknowledgement form date 7/27/25, showed Resident 85 did not executed an advance directive. On 8/11/2025 at 0913 hours, an observation and concurrent interview was conducted with Resident 85. Resident 85 was observed in bed eating breakfast. Resident 85 was asked if she had an advance directive. Resident 85 stated she had an advance directive and she formulated the advance directive when she was admitted at the facility before. Resident 85 stated her daughter had the copy of the advance directive. Resident 85 was asked if she provided a copy to the facility, she stated she did not remember. On 8/11/2025 at 0933 hours, a telephone interview was conducted with Family Member 1. Family Member 1 was asked about Resident 85's advance directive. Family Member 1 verified and acknowledged Resident 85 had an advance directive. Family Member 1 stated her mother was in and out of the facility and she had formulated an advance directive before. When asked if the facility staff had asked her about the advance directive, Family Member 1 stated no. Family member 1 added if the facility asked for the advance directive, she could give them a copy. On 8/11/2025 at 0959 hours, an interview and concurrent medical record review for Residents 28 and 85 was conducted with the SSD. The SSD was informed about Residents 28 and 85's advance directive documentation information and the conflicting information on the residents' medical record. The SSD verified and acknowledged he was not aware about the conflicting information about the advance directive of Residents 28 and 85. On 8/11/2025 at 1139 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**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 three of five final sampled residents (Residents 28, 65, and 69) reviewed for unnecessary medications were monitored for the identified manifested episode of behavior and provided with the non-pharmacological interventions for the use of psychotropic medications. * The facility failed to ensure Resident 28's target behavior for the use of the mirtazapine (antidepressant) was monitored accurately. In addition, the facility failed to ensure Resident 28's monthly behavior monitoring summary was completed for the use of the antidepressant medication. * The facility failed to ensure Resident 65 received accurate monitoring for the behavioral episodes and provided with the appropriate non-pharmacological interventions while being administered the Remeron (antidepressant), Risperdal (antipsychotic), and Trazodone (antidepressant) medications. Additionally, the facility failed to provide the monthly behavior monitoring summaries for June and July 2025 for the Risperdal and Trazodone medications. * The facility failed to ensure Resident 69's medical record showed the physician's clinical rationale for continuing the PRN Ativan (antianxiety) medication beyond a 14 day treatment period. In addition, the facility failed to implement the non-pharmacological interventions and complete the monthly behavior monitoring summary for the resident's Ativan use. These failures had the potential to negatively impact the residents' health outcomes and well-being.Findings:<br><br>Review of the facility's P&P titled Use of Psychotropic Medication(s) dated 3/17/25, showed the psychotropic medications are to be used only when a practitioner determines that the medication(s) is appropriate to treat a resident's specific, diagnosed, and documented condition and the medication(s) is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Non-pharmacological interventions must be attempted unless clinically contraindicated to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medication.<br><br>1. Medical record review for Resident 65 was initiated on 8/5/25. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>a. Review of Resident 65's Order Summary Report dated 8/6/25, showed a physician's order dated 6/30/25, to monitor the Remeron medication for depression manifested by poor PO intake, and record the number of times the behavior was manifested every shift.<br><br>Review of Resident 65's Monitor Record form for July 2025 showed the following entries for the Remeron medication for depression manifested by poor PO intake:<br><br>- on 7/2/25, from 2300 to 0700 hours, the documentation was left blank.<br><br>- on 7/4/25, from 0700 to 1500 hours, the documentation was left blank.<br><br>- on 7/6/25, from 0700 to 1500 hours and from 1500 to 2300 hours, the documentation was left blank.<br><br>Review of Resident 65's Follow-Up Question Report dated 8/6/25, showed the following specific resident intake percentages:<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - on 7/5/25 at 0800 hours, 7/9/25 at 1309 hours, 7/10/25 at 1109 hours, 7/14/25 at 1438 hours, 7/15/25 at 1217 hours, and 7/16/25 at 1323 hours: 40%;<br><br>- on 7/8/25 at 1132 hours: 35%;<br><br>- on 7/21/25 at 1249 hours and 7/22/25 at 1105 hours: 20%;<br><br>- on 7/22/25 at 2110 hours: 25%;<br><br>- on 7/24/25 at 2234 hours: 10%; and<br><br>- on 7/30/25 at 1246 hours: 30%.<br><br>b. Review of Resident 65's Order Summary Report dated 8/6/25, showed a physician's order dated 5/15/25, to monitor the risperidone medication for schizophrenia manifested by auditory hallucinations (hearing voices), and record the number of times the behavior is manifested every shift.<br><br>Review of Resident 65's Psychopharmaceutical Summary Sheet for the risperidone medication showed:<br><br>- on 5/25/25, one episode of the behavior was documented.<br><br>However, there was no documentation for the number of episodes of manifested behavior for June and July 2025.<br><br>c. Review of Resident 65's Order Summary Report dated 8/6/25, showed a physician's order dated 6/20/25, to monitor the trazodone medication for depression manifested by verbalizations of inability to sleep, and record the number of times the behavior is manifested every shift.<br><br>Review of Resident 65's Psychopharmaceutical Summary Sheet for the trazodone medication showed:<br><br>- on 5/25/25, zero episodes were documented.<br><br>However, there was no documentation for the number of episodes of manifested behavior for June and July 2025.<br><br>On 8/6/25 at 0945 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 was asked how he monitored the residents for the use of the Remeron medication. LVN 3 stated the licensed nurses counted an episode of poor PO intake when a resident consumed less than 30% of the meal. LVN 3 stated the CNAs documented the percentage of the residents' meal intake, and the licensed nurses would count one episode if the resident ate less than 30%. LVN 3 was asked if Resident 65 had verbalized any auditory hallucinations or reported hearing voices to the facility staff. LVN 3 stated Resident 65 had not verbalized auditory hallucination or hearing voices during his shift. In addition, LVN 3 stated the resident had not reported having trouble sleeping during his shift.<br><br>On 8/6/25 at 1000 hours, an interview was conducted with CNA 7. CNA 7 was asked when she would consider Resident 65 to have poor PO intake. CNA 7 stated she would report to the licensed nurse if Resident 65 ate less than 50% of the meal. CNA 7 verified Resident 65 had a episodes of eating less than 50% of the meal, as documented above.<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/6/25 at 1015 hours, an interview and concurrent medical record review was conducted with the Quality Assurance Nurse (QA Nurse). When asked, the QA Nurse stated the licensed nurses monitored and documented for the poor PO intake episode when the residents' meal intake was less than 50%. When asked how the licensed nurses monitored for the residents' poor PO intake, the QA Nurse stated the CNAs documented the residents' meal intake for breakfast, lunch, and dinner, and the licensed nurses reviewed the CNAs' documentation and recorded the episodes on the residents' Monitoring Record form. The QA Nurse reviewed Resident 65's Follow-Up Question Report dated 8/6/25, and stated the licensed nurses should have documented all the episodes where the resident's meal intake was less than 50% on Resident 65's Monitor Record form. The QA Nurse verified the CNAs' documentation (Follow-Up Question Report) for the resident's meal intake did not match the behavior monitoring form for the use of the Remeron medication. In addition, the QA nurse was asked if there was documentation to show the non-pharmacological interventions were provided prior to the use of Remeron, trazodone, and Risperdal medication but the QA Nurse was unable to provide the documentation. The QA Nurse stated there was no monthly behavior monitoring summary for June and July 2025 for the trazodone and risperidone medications, and no monthly behavior monitoring summary for July 2025 for the Remeron medication. The QA Nurse verified the above findings.<br><br>On 8/6/25 at 1240 hours, an interview was conducted with RN 1. RN 1 stated the licensed nurses documented an episode of poor PO intake when the residents' meal intake was less than 60%.<br><br>On 8/7/25 at 1140 hours, an interview and concurrent medical record review was conducted with the DON. The DON was informed and acknowledged the above findings.<br><br>2. Medical record review for Resident 69 was initiated on 8/5/25. Resident 69 was admitted to the facility on [DATE].<br><br>Review of Resident 69's physician's orders showed the following:- dated 7/11/25, to administer Ativan 0.5 mg via GT every six hours PRN for anxiety manifested by the inability to relax, with an order duration of 14 days.- dated 7/30/25, to administer Ativan 0.5 mg via GT every six hours PRN for anxiety manifested by the inability to relax, with an order duration of 14 days.<br><br>Review of Resident 69's MAR for July and August 2025 showed the following:- Resident 69 received 28 doses of the Ativan medication in July 2025.- Resident 69 received 12 doses of the Ativan medication in August 2025.<br><br>Further review of Resident 69's medical record failed to show the physician's clinical rationale for continuing the Ativan medication beyond the 14-day period, the monthly behavior monitoring summary for the targeted behavior of the Ativan medication for July 2025,and if the non-pharmacological interventions were implemented prior to administering PRN Ativan medication.<br><br>On 8/7/25 at 1437 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 69's medical record and verified the resident's medical record failed to show the physician's rationale for the continued PRN Ativan use, July's monthly behavior monitoring summary for the targeted behavior, and if the non-pharmacological interventions were attempted prior to administering PRN Ativan.<br><br>3. Medical record review for Resident 28 was initiated on 8/6/25. Resident 28 was admitted to the facility on [DATE], with a diagnosis of depression.<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident Order Summary Report dated 8/7/25, showed the following physician's orders:<br><br>- dated 6/3/25, and discontinued on 8/6/25, to administer mirtazapine 0.5 mg tablet by mouth at bedtime for depression manifested by poor intake less than 50% of each meal.<br><br>- dated 6/3/25, to monitor poor intake less than 50% of meals and record the number of times the behavior was manifested every shift.<br><br>Review of Resident 28's Nutrition Amount Eaten record for the last 30 days showed on 7/10, 7/11, 7/18, 7/22, 7/26, 7/27, 7/28, 8/2, 8/4, and 8/5/25, Resident 28 consumed less than 50% of his meals.<br><br>Review of Resident 28's Monitor Record form from 7/1 to 7/31/25, showed the monitoring of the poor intake less than 50% of meals showed zero number of times the behavior manifested every shift.<br><br>Further review of Resident 28's medical record failed to show documented evidence the monthly behavior monitoring summary was completed for the mirtazapine medication.<br><br>On 8/7/25 at 1043 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 1. RN 1 verified and acknowledged Resident 28 was on an antidepressant medication and was monitored for poor intake less than 50% of the meals. RN 1 was asked who determined the meal percentage of Resident 28. RN 1stated the CNAs recorded the meal percentage on the residents' meal percentage record. RN 1 was able to show Resident 28's meal percentage record for the past 30 days and verified there were episodes where the resident consumed less than 50% of the meal. When RN 1 was asked about the monitoring of the behavior for the resident, RN 1 was able to show the Monitor Record form for July 2025 and verified there were zero behavior episodes documented for the poor intake less than 50%. RN 1 verified and acknowledged the monitoring of the behavior for poor intake was inaccurate. RN 1 was asked if there was a monthly behavior monitoring summaries documented for Resident 28's poor intake for the past months. RN 1 reviewed the resident's medical record and verified there was no monthly behavior monitoring summaries documented and completed for the use of the mirtazapine medication.<br><br>On 8/7/25 at 1125 hours, an interview and concurrent medical record review for Resident 28 was conducted with the DON. The DON was asked about the residents on antipsychotic medications. The DON stated the facility staff monitored the residents and made sure the medication was being given to resident and the targeted behavior was monitored. The DON was informed of the inconsistency and inaccurate monitoring for the behavior of the poor intake for Resident 28's use of the mirtazapine medication. In addition, the DON was informed the monthly behavior monitoring summaries were not completed. The DON verified and acknowledged the above findings.<br><br>Cross Reference F756, example # 2. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and the facility P&P review, the facility failed to develop the comprehensive plans of care to reflect the individual care needs for four of 21 final sampled residents (Residents 3, 5, 8, and 59). * The facility failed to develop a care plan problem for Resident 3's use of the central line and IV antibiotic medication. * The facility failed to develop a care plan problem for Resident 5's use of the midline IV and maintenance care. * The facility failed to implement a care plan specific to the administration of oxygen. Resident 8 received continuous oxygen at a rate of 4 LPM, however, physician's order was for 3 LPM. * The facility failed to develop a care plan problem for the use Resident 59's right upper arm PICC line. These failures posed the risk of not providing appropriate, consistent, and individualized care to these residents. Findings:<br><br>Review of the facility's P&P titled Comprehensive Care Plans dated 12/19/22, showed the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan will be developed within seven days after the completion of the comprehensive assessment. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record.<br><br>1. Medical record review for Resident 3 was initiated on 8/6/25. Resident 3 was admitted to the facility on [DATE].<br><br>On 8/6/25 at 1117 hours, an observation and concurrent interview for Resident 3 was conducted with LVN 1. LVN 1 was asked at Resident 3's bedside about the resident's IV access. LVN 1 donned the disposable gloves and asked Resident 3 if LVN 1 could check his IV access and Resident 3 agreed. LVN 1 was observed lifting Resident 3's clothing and exposed the resident's chest. Two lumen central line with dry dressing was observed on the resident's left upper chest. LVN 1 stated the central line was the resident's PICC line.<br><br>Review of Resident 3's Order Summary Report dated 8/5/25, showed the following physician's orders:<br><br>- dated 7/30/25, to measure the external catheter length of the PICC line and measure the arm circumference upon admission and every seven days for site maintenance and as needed.<br><br>- dated 7/30/25, to change the PICC transparent dressing by sterile technique upon admission and every day shift every seven days for site maintenance as needed.<br><br>- dated 8/1/25, to administer piperacillin (antibiotic) solution reconstituted 3.375 gm intravenously every 12 hours for wound infection.<br><br>Review of Resident 3's plan of care failed to show documented evidence a care plan problem was developed to address Resident 3's use of the IV central line and IV antibiotic.<br><br>On 8/6/25 at 1112 hours, an interview for Resident 3 was conducted with LVN 5. LVN 5 stated<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 3 was on IV antibiotic medication for the foot wound infection. LVN 5 stated Resident 3 had an IV access to his left upper chest.<br><br>On 8/6/25 at 1335 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. When RN 1 was asked about the plan of care for Resident 3's use of the central line and IV antibiotic medication, RN 1 reviewed the resident's care plan and verified there was no care plan developed for the use of central line and the IV antibiotic medication.<br><br>On 8/11/2025 at 1125 hours, an interview for Resident 3 was conducted with the DON. The DON was informed and verified the above findings.<br><br>Cross reference to F694, example # 4.<br><br>2. Medical record of Resident 5 was initiated on 8/5/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 5's Order Summary Report dated 8/5/25, showed a physician's order dated 7/14/25, to measure the external catheter length of the midline and measure the arm circumference upon admission and as needed for site maintenance.<br><br>Review of Resident 5's plan of care showed a care plan dated 7/23/25, addressing Resident 5's skin alteration to the right lateral heel area, left lateral malleolus area, and right lower abdominal area. The interventions included administering the intravenous antibiotic as ordered and to monitor for side effects. However, the resident's plan of care failed to show a care plan problem was developed to address the resident's use and maintenance of the IV midline.<br><br>On 8/6/25 at 1230 hours, an interview and concurrent medical record review was conducted with RN 1. When RN 1 was asked to show the care plan to address the resident's use and maintenance of the midline IV, RN 1 was unable to show the documentation. RN 1 verified the above findings.<br><br>3. Medical record review for Resident 8 was initiated on 8/5/25. Resident 8 was admitted to the facility on [DATE].<br><br>Review of Resident 8's physician's order dated 12/17/24, showed an order to administer continuous oxygen via nasal cannula at a rate of three LPM.<br><br>Review of Resident 8's care plan titled Risk for Difficulty Breathing, End Stage CHF revised 1/8/25, showed to administer oxygen via nasal canula as ordered.<br><br>On 8/5/25 at 0900 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed lying in bed and receiving continuous oxygen via a nasal cannula at a rate of four LPM. Resident 8 stated the licensed nurses at the facility had set the rate of her oxygen.<br><br>On 8/5/25 at 0952 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2. Resident 8 was observed lying in bed and receiving continuous oxygen via a nasal cannula at a rate of four LPM. LVN 2 reviewed Resident 8's current physician's orders and verified Resident 8's physician's order showed to administer continuous oxygen via nasal cannula at a rate of three LPM. LVN 2 then reviewed Resident 8's care plan titled Risk for Difficulty Breathing, End Stage CHF revised 1/8/25, which showed to administer oxygen via nasal canula as ordered. LVN 2 (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was then observed lowering Resident 8's continuous oxygen to a rate of three LPM, in accordance with the physician's order and comprehensive care plan for the use of oxygen.<br><br>4. Medical record review for Resident 59 was initiated on 8/5/25. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's progress notes dated 7/9/25, showed Resident 59 was admitted to the facility with a right upper arm PICC line with two-lumens.<br><br>Review of Resident 59's Order Summary Report dated 8/6/25, showed the following physician's orders:<br><br>- dated 7/10/25, to change the PICC/midline transparent dressing per sterile technique upon admission, every Sunday, and as needed every day shift.<br><br>- dated 7/10/25, to measure the external catheter length of the PICC/midline and measure the arm circumference upon admission and with every dressing change on Sunday and PRN, for site maintenance.<br><br>Review of Resident 59's plan of care failed to show a care plan problem to address the use of Resident 59's right upper arm PICC line.<br><br>On 8/5/25 at 0824 hours, Resident 59 was observed with a PICC line with two-port external catheters to the right upper arm (RUA). The transparent dressing over the PICC line was dated 7/30/25.<br><br>On 8/6/25 at 1324 hours, an interview and concurrent medical record review for Resident 59 was conducted with RN 2. RN 2 stated Resident 59 had a PICC line in the RUA and was currently receiving intravenous antibiotics. RN 2 reviewed Resident 59's medical record and verified the above findings. RN 2 stated there should be a care plan to address the use, care, and management of Resident 59's RUA PICC line.<br><br>On 8/11/25 at 1207 hours, an interview was conducted with the DON. The DON stated for the residents admitted to the facility with a PICC line, there should be a care plan developed to address the management of the residents' PICC line.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON and Nurse Consultant. The Administrator, DON and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to to ensure feeding assistance was provided per the physician's order for one of 21 residents (Resident 5) observed during the dining observation. * During the dining observation, the facility failed to provided one to one feeding assistance for Resident 5. Resident meal card showed the resident required total assistance with feeding. This failure has the potential to negatively affect the resident's health outcomes and well-being. Findings: Review of the facility's P&P titled Meal Supervision and Assistance dated 12/19/22, showed the resident will be prepared for a well-balanced meal in a calm environment, location of his / her preference and with adequate supervision and assistance to prevent accidents, provide adequate nutrition, and assure an enjoyable event. This includes: Identifying hazard(s) and risk(s), Evaluating and analyzing hazard(s) and risk(s), Implementing interventions to reduce hazard(s) and risk(s), and monitoring for effectiveness and modifying interventions when necessary assemble equipment and supplies needed. Do not serve the meal until the attendant is ready to assist the resident. Medical record review for Resident 5 was initiated on 8/5/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's plan of care showed a care plan dated 7/31/25, addressing the resident's potential for nutritional problem. However, there was no care plan addressing the resident's need for total assistance with feeding and/or interventions to provide Resident 5 with one to one assistance with feeding during meals. Review of the Resident 5's Order Summary Report dated 8/5/25, showed a physician's order dated 7/14/25, for one to one feeder. Review of Resident 5's meal card dated 8/5/25, showed Resident 5 required total assistance with feeding. On 8/5/25 at 1300 hours, Resident 5 was observed sitting up in the middle of the bed with a bedside table in front of her. A closed lunch tray and utensils were placed in front of her. Resident 5 stated she was hungry and had been waiting for the facility staff for 10 minutes to assist her with her lunch. Resident 5 stated she needed assistance because she could not see her meal. Resident 5 stated the facility staff had delivered her meal tray but did not inform her whether they would return or provided assistance to her with setting up the meal tray and the utensils. Resident 5 was observed feeling around the meal tray with her hands, lifting the cover, and locating the utensils. Resident 5 was observed using the utensils to scoop the carrots and potatoes with difficulty, and eventually used her hands to eat a few pieces of the food. Resident 5's meal card showed the resident required total assistance. On 8/5/25 at 1310 hours, an observation and concurrent interview was conducted with Resident 5. Resident 5 stated she needed help with feeding and could not eat the rest of her food. Resident 5 was observed using the call light to request for facility staff assistance. On 8/5/25 at 1320 hours, an observation and concurrent interview was conducted with the IP. Resident 5's call light remained on and there was no facility staff present in the hallway. The IP was summoned to Resident 5's room. Resident 5 then asked the IP if any of the facility staff could help to feed her. Resident 5 was observed attempting to get the food with her hands. The IP was informed of the above observation. The IP stated Resident 5 always required the facility staff assistance with feeding and stated she would find a facility staff to help the resident. The IP verified the findings. On 8/5/25 at 1330 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was observed assisting Resident 5 with her meal. CNA 3 stated she was asked by the IP to help feed Resident 5 and she thought the assigned sitter (CNA 4) would provide assistance with Resident 5's meals. On 8/5/25 at 1335 hours, an interview was conducted with the DSD. The DSD stated CNA 4 was assigned to Resident 5, however, CNA 4 had arrived late this morning and had gone on a break at a later time. The DSD stated CNA 4 was expected to return from her break in 10 minutes. On 8/5/25 at 1600 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 was informed of the above findings. LVN 6 stated Resident 5 was totally blind and required total assistance with feeding. LVN 6<br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | reviewed Resident 5's plan of care and verified there was no care plan and/or interventions addressing the resident's need for total assistance with feeding. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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 one of three final sampled residents (Resident 10) reviewed for accidents remained free from accident hazards. * Resident 10 sustained three falls while the sitter (facility staff who provides direct supervision to those residents requiring close monitoring) was distracted, and/or had left the room. * Resident 10's post fall neurological assessments were incomplete for the falls sustained on 3/3 and 8/5/25. * Resident 10's post fall, fall risk assessments were inaccurate for 7/27/25 and incomplete for 8/5/25. * The facility failed to ensure Resident 10 remained within the sitter's eyesight for 11 minutes. These failures resulted in the resident sustaining subsequent falls had the potential to place the resident at risk for serious injury and negative health outcomes. Findings: Medical record review for Resident 10 was initiated on 8/5/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's eINTERACT Change in Condition Evaluation - V 5.1 assessments showed the resident had falls on the following dates: 3/22, 4/1, 4/3, 6/27, 7/12, 7/27, and 8/5/25. Review of Resident 10's Care Plan Report showed a care plan problem addressing the resident's actual fall revised on 7/17/25. The interventions included to monitor the resident more frequently. The report also showed care plan problem addressing the resident's risk for falls dated 7/1/25. The interventions included to anticipate and meet the resident's needs, and to follow the facility's fall protocol. 1. a. Further review of Resident 10's eINTERACT Change in Condition Evaluation - V 5.1 assessment dated [DATE], showed the resident's sitter left the resident's room while the resident was sleeping and when the sitter returned, the resident was found lying on the floor, and stated he tried to get to the bathroom. Review of Resident 10's Interdisciplinary Care Conference - V 5 dated 7/2/25, showed the team met to discuss the resident's fall on 6/27/25. The recommendations showed the sitter was instructed on the importance of not leaving the resident's room except in an emergency. b. Further review of Resident 10's eINTERACT Change in Condition Evaluation - V 5.1 assessment dated [DATE], showed a sitter was assigned to Resident 10 and his roommate, the sitter reported Resident 10 was agitated and when the sitter went to assist the roommate, Resident 10 had a fall. c. Review of Resident 10's progress notes dated 8/5/25 at 2101 hours, showed the resident had an unwitnessed fall and was found on the floor. On 8/8/25 at 1014 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated a sitter was assigned to Resident 10 and his roommate. Resident 10 had a sitter since he was readmitted to the facility on [DATE]. The DON stated the sitter was supposed to monitor the residents for safety, and not to provide resident care, so both the residents could be monitored. The DON stated for Resident 10's falls on 6/27 and 8/5/25, he had the falls when his sitter had left the room. The DON also stated for the resident's fall on 7/12/25, the sitter was assisting Resident 10's roommate, when Resident 10 had his fall. The DON stated the sitter's role was to monitor the residents for safety, and if the residents needed assistance, the sitter should have requested for the facility staff to assist them. 2. a. Review of Resident 10's post-fall Neurological Flowsheet - V 3 dated 4/3/25 at 1330 hours, showed a neurological assessment #14 was completed on 4/4/25 at 0930 hours, and the assessment #15 was scheduled four hours later at 1330 hours. The neurological assessment #15 was not completed. Review of Resident 10's progress notes dated 4/4/25 at 1448 hours, showed the resident was discharged to the community. b. Review of Resident 10's post-fall Neurological Flowsheet - V 3 dated 8/5/25 at 2045 hours, showed the following incomplete neurological assessments:- Assessment # 15, due to be completed on 8/6/25 at 1625 hours.- Assessment # 16, due to be completed on 8/7/25 at 0025 hours.- Assessment # 18, due to be completed on 8/7/25 at 1745 hours. On 8/8/25 at 1014 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 10's medical record and verified the post fall Neurological Flowsheet - V 3 dated<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 4/3/25 at 1330, was incomplete and the final neurological assessment should have been completed on 4/4/25 at 1330, since the resident's medical record showed the resident was still in the facility at the time. The DON also verified the post-fall Neurological Flowsheet - V 3 dated 8/5/25, had an incomplete assessments for Numbers 15, 16, and 18. 3. Review of the facility's P&P titled Fall Prevention Program revised 12/28/23, showed after a resident fall, the facility will complete post-fall assessment. Review of Resident 10's Fall Risk - V 4 dated 7/27/25, incorrectly showed the resident had no falls in past three months, which resulted in a fall risk score of nine. Review of Resident 10's Fall Risk - V 4 dated 8/5/25, showed assessment was blank, and no information documented. On 8/8/25 at 1014 hours, an interview and concurrent medical record review was conducted with the DON. The DON reviewed Resident 10's medical record and stated the above Fall Risk - V 4 assessments were completed post fall. The DON verified the assessment dated [DATE], was incorrectly completed and the assessment dated [DATE], was blank but should be completed immediately after the resident's fall. 4. On 8/8/25 at 0923 hours, while LVN 1 was preparing for Resident 10's wound care treatment, LVN 1 was standing at the treatment cart outside of Resident 10's doorway. LVN 1 went into the resident's room, washed her hands and came back out to her treatment cart in the hallway. Resident 10 was not visible from the doorway as his privacy curtain was completely closed. CNA 1 was observed standing inside the resident's room by the doorway and by the roommate's (Resident 69) bed. LVN 1 remained at her treatment cart gathering supplies. On 8/8/25 at 0934 hours, after 11 minutes later, LVN 1 went to Resident 10's bedside for a wound care treatment observation. Upon walking around to the other side of Resident 10's privacy curtain, Resident 10 was observed sleeping on the bed, with no other facility staff observed at the resident's bedside or visible from the resident's bedside with the privacy curtain in place. On 8/8/25 at 1014 hours, an interview was conducted with CNA 1 who was still standing inside the doorway next to Resident 69's bedside. CNA 1 stated she was the sitter for Residents 10 and 69. When asked how she was able to monitor Resident 10 with his privacy curtain pulled and blocking her view of him for the 11 minutes, while LVN 1 was at the treatment cart in the hallway, CNA 1 was unable to give an appropriate answer and stated she was waiting for the LVN to come into the room. On 8/8/25 at 1014 hours, an interview was conducted with the DON. The DON stated since Residents 10 and 69 were both fall risks and Resident 10 had frequent falls, the facility decided to assign a sitter to monitor the residents for safety. The DON stated the facility decided to utilize a sitter when the resident was readmitted to the facility on [DATE]. The DON stated the CNA should not have the privacy curtain pulled, obstructing her view of the resident while monitoring him. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**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 appropriate care and services for the use of the GT (gastrostomy tube- a small tube placed through the abdominal wall into the stomach, used to provide enteral feedings and/or administer medications) for one of three final sampled residents (Resident 4) reviewed for the GT feeding and one of three residents (Resident 2) observed for the medication administration. * The facility failed to ensure LVN 3 checked for the gastric residual (volume of fluid remaining in the stomach) prior to the administration of the GT medications for Resident 2 and failed to flush the GT between the administration of each medication. * LVN 6 failed to verify Resident 4's GT placement prior to administering the tube feeding. These failures posed the risk of complications related to the use of the GT for Residents 2 and 4.Findings:<br><br>Review of the facility's P&P titled Appropriate Use of Feeding Tubes revised 12/19/22, showed the feeding tubes will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The plan of care will address the use of feeding tubes, including strategies to prevent complications.<br><br>1. Medical record review for Resident 2 was initiated on 8/6/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 2's Order Summary Report dated 8/6/25, showed the following physician's orders:<br><br>- dated 6/10/25, to flush the enteral feeding tube with 15-30 ml of water before and after the medication administrations; and<br><br>- dated 6/10/25, to check the residual volume every shift. To hold the enteral feeding if the residual exceeds 100 ml. To recheck the residual in one hour and notify the physician if the residual volume is more than 100 ml on the second check.<br><br>Review of Resident 2's plan of care showed a care plan problem dated 6/12/25, addressing Resident 2's use of the GT feeding. The interventions included to check for the GT placement and gastric contents/residual volume per the facility protocol and record, to hold the enteral feeding if the residual volume was greater than 100 ml aspirated, and to provide water flushes with medications per the nursing policy.<br><br>On 8/6/25 at 0800 hours, a medication administration observation was conducted with LVN 3. LVN 3 was observed preparing the following GT medications:<br><br>- one packet of Juven (wound healing supplement) mixed in six-ounces of water;<br><br>- one tablet of vitamin C (supplement) 500 mg;<br><br>- two tablets of docusate sodium (stool softener) 100 mg;<br><br>- one table of simethicone (gas relief) 125 mg;<br>(continued on next page) |

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| Bonita Hills Post Acute | 1233 West LA Habra Boulevard<br>LA Habra, CA 90631 |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | - 30 ml of LiquaCel (liquid protein);<br><br>- 5 ml of MultiVite Liquid (supplement); and<br><br>- 17gm of polyethylene glycol (laxative) 3350.<br><br>LVN 3 was observed checking for the GT placement by injecting air and auscultating the resident's abdomen. LVN 3 was observed flushing the GT with 30 ml of water prior to the GT medication administration. LVN 3 was not observed checking Resident 2's gastric residual volume. LVN 3 then proceeded to administer the above GT medications to Resident 2. LVN 3 was not observed flushing the GT with water in between each of the medications.<br><br>On 8/6/25 at 0844 hours, an interview was conducted with LVN 3. LVN 3 was asked about the facility's protocol for the administration of a medication via the GT. LVN 3 stated for the administration of the medications via the GT, the enteral feeding should be placed on hold, and the licensed nurse should check for the GT placement by pushing 5-10 ml of air and auscultating for the sound. LVN 3 stated the licensed nurse should then aspirate to check for the gastric residual. LVN 3 further stated the GT medications were administered by gravity and in between each medications, the licensed nurse should flush the GT with 5 ml of water. LVN 3 verified during the medication administration observation, he did not check for the gastric residual prior to the administration of the medications, and he did not flush the GT with water in between each of the medications.<br><br>On 8/11/25 at 0841 hours, an interview was conducted with the DON. The DON stated for the administration of the medications via the GT, the licensed nurses were expected to check for the GT placement and check for the gastric residual. The DON stated the licensed nurse should flush the GT with 10-30 ml of water before and after the medication administration, and in between each medications, the licensed nurse should flush the GT with 5 to 10 ml of water.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON and Nurse Consultant. The Administrator, DON and Nurse Consultant were informed and acknowledged the above findings.<br><br>2. Review of the facility's P&P titled Verifying Placement of Feeding Tubes dated 12/19/22, showed before a feeding, flushing the tube, or administering medications via a feeding tube, proper placement should be verified. Verify tube placement by auscultating the abdomen while giving an air bolus into the tube.<br><br>Medical record review for Resident 4 was initiated on 8/6/25. Resident 4 was readmitted to the facility on [DATE].<br><br>Review of Resident 4's Order Summary Report showed a physician's order dated 6/6/25, to administer the Osmolyte1.2 (type of enteral feeding) via GT daily at 1300 hours.<br><br>On 8/6/25 at 1350 hours, LVN 6 was observed initiating Resident 4's GT feeding. LVN 6 checked the GT for residuals, and no residuals was observed. LVN 6 then flushed the GT with water and started the tube feeding. LVN 6 was not observed verifying Resident 4's GT placement with auscultation prior to flushing the GT and starting the tube feeding. LVN 6 verified she did not verify the resident's GT placement because placement only needed to be verified once a shift and she verified the placement when she administered the resident's morning medication.<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/6/25 at 1514 hours, an interview was conducted with the DON. The DON verified the facility P&P showed to verify GT placement with auscultation before administering water flushes, tube feeding, and GT medications. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**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 care and services to maintain the IV accesses for four of four final sampled residents (Residents 3, 5, 59, and 83) reviewed for IV care. * The facility failed to ensure there was a physician's order for the use of Resident 3's central line. * The facility failed to ensure Resident 5's midline dressing was dated and failed to ensure for complete documentation of the maintenance flushes, as per the physician's orders. * The facility failed to ensure Resident 59's right upper arm PICC line was changed as per the physician's orders and failed to ensure Resident 59's PICC line external catheter and arm circumference measurements were obtained and documented in the resident's medical record. * The facility failed to ensure there was a physician's order for the care and maintenance of Resident 83's left upper arm midline and failed to ensure Resident 83's midline dressing was changed weekly. These failures had the potential to delay the identification of a catheter related complications for the residents.Findings:<br><br>Review of the facility's P&P titled PICC/Midline/CVAD Dressing changed revised 12/19/22, showed it is the policy of this facility to change the peripherally inserted central catheter (PICC), midline or central venous access device (CVAD) dressing, weekly or if soiled, in a manner to decrease the potential for infection and/or cross contamination. To use sterile measuring tape to measure the external length of the catheter from the hub to skin entry to ensure that it has not migrated. To apply a transparent semi-permeable dressing to the insertion site. To label the dressing with the date, time and initials; and to document the procedure.<br><br>1. On 8/5/25 at 0824 hours, Resident 59 was observed with the two port external catheters PICC line to the right upper arm. The transparent dressing over Resident 59's right upper arm PICC line was dated 7/30/25.<br><br>Medical record review for Resident 59 was initiated on 8/5/25. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's progress notes dated 7/9/25, showed Resident 59 was admitted to the facility with a right upper arm PICC line, with two-lumens. However, further review of the resident's progress note failed to show any documentation of Resident 59's baseline PICC line external catheter length and arm circumference measurements.<br><br>Review of Resident 59's Order Summary Report dated 8/6/25, showed the following physician's orders:<br><br>- dated 7/10/25, to change the PICC/midline transparent dressing per sterile technique upon admission, every Sunday, and as needed every day shift.<br><br>- dated 7/10/25, to measure the external catheter length of the PICC/midline and measure the arm circumference upon admission and with every dressing change on Sunday and PRN, for site maintenance.<br><br>Review of Resident 59's PICC Insertion Record dated 7/18/25, showed Resident 59 had a new PICC line with two-lumens (external ports) inserted in the right upper extremity. The document showed the external length measurement was 3 cm and the arm circumference was 40 cm.<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 59's IV Administration Report for July 2025 showed the following documentation:<br><br>- On Sunday 7/20 and 7/27/25, the documentations for the external catheter length and arm circumference measurements for Resident 59's PICC line, and for the PICC line transparent dressing change, upon admission and every Sunday were left blank.<br><br>- On 7/30/25 (the date observed on Resident 59's PICC line dressing), the IV Administration Record failed to show the documentation of Resident 59's PICC line external catheter length and arm circumference measurements.<br><br>Further review of Resident 59's progress notes failed to show the licensed nurses' entry of the measurements for Resident 59's arm circumference and PICC line external catheter length.<br><br>On 8/6/25 at 1324 hours, an interview and concurrent medical record review for Resident 59 was conducted with RN 2. RN 2 stated Resident 59 had a PICC line in the RUA and was currently receiving intravenous antibiotics. RN 2 stated the PICC line dressings were changed weekly and as needed and documented in the IV Administration Record. RN 2 stated during the PICC line dressing change, the external catheter length and the resident's arm circumference were measured and compared to the previous measurements. RN 2 reviewed Resident 59's medical record and verified the above findings.<br><br>2. On 8/5/25 at 0910 hours, Resident 83 was observed with a left upper arm midline with the dressing dated 7/23/25.<br><br>Medical record review for Resident 83 was initiated on 8/5/25. Resident 83 was admitted to the facility on [DATE].<br><br>Review of Resident 83's N ADV-Clinical admission dated 7/25/25, under the Special Care section, the licensed nurse documented Resident 83 had a midline in the left upper arm.<br><br>Review of Resident 83's progress notes dated 7/25/25, showed Resident 83 was admitted to the facility with a midline in the left upper arm for the continuation of the antibiotics. However, further review of the progress notes failed to show any documentation of Resident 83's midline measurements.<br><br>Review of Resident 83's Order Summary Report failed to show a physician's order for the use and maintenance of Resident 83's midline in the left upper arm.<br><br>Review of Resident 83's IV Administration Record failed to show documentation Resident 83's midline dressing was changed.<br><br>On 8/5/25 at 1616 hours, an interview, observation, and concurrent medical record review for Resident 83 was conducted with RN 1. RN 1 stated the dressing changes for the midlines and PICC lines should be done weekly. RN 1 reviewed Resident 83's medical record and verified the above findings. RN 1 verified Resident 83's midline dressing in the left upper arm was dated 7/23/25 (before her admission to the facility) and had not been changed since her admission to the facility.<br><br>On 8/11/25 at 0841 hours, an interview was conducted with the DON. The DON stated for the residents admitted to the facility with a PICC line or midline, the dressing should be changed upon admission and weekly. The DON stated upon admission to the facility, the licensed nurse should<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | obtain the baseline measurements, which included the external catheter length, to ensure the catheter did not dislodge during the transfer. and the arm circumference measurement, to assess for swelling of the access site. The DON stated the PICC line and midline dressing should be changed weekly and as needed, and the licensed nurses were expected to measure the external catheter length and arm circumference, document the measurements in the IV Administration Record, and compare the measurements with the previous measurements.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.<br><br>3. Review of the facility's P&P titled Intravenous Therapy dated 12/19/22, showed all the intravenous tubing is to be labeled with date, time and initials. IV documentation is recorded in the nurses' notes and/or Medication Administration Record.<br><br>Medical record for Resident 5 was initiated on 8/5/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>On 8/5/25 at 0830 hours, Resident 5 was observed with a midline in the left arm and undated dressing.<br><br>Review of Resident 5's Order Summary Report dated 8/5/25, showed a physician's orders dated 7/14/25:<br><br>- to measure external catheter length of the midline and measure arm circumference upon admission and as needed for site maintenance.<br><br>- Normal saline (sterile solution of 0.9% sodium chloride in water) flush intravenous solution 0.9 %: use 10 ml intravenously every shift for line maintenance. Flush the midline with 10 ml of normal saline before and after medication administration.<br><br>- Site checks: monitor for signs and symptoms of complications or adverse reactions from IV therapy every shift.<br><br>- To administer cefepime hydrochloride (antibiotic) intravenous solution 2 gram/100 milliliter: use 2 gram intravenously every 12 hours for abdomen wall abscess for two weeks .<br><br>Review of Resident 5's IV Administration Report for July 2025 showed the following:<br><br>- Missing documentation for the cefepime HCl 2 gram intravenously every 12 hours for abdominal wall abscess for two weeks on 7/18, 7/19, and 7/26/25 at 2100 hours.<br><br>- Missing documentation for the normal saline flush 0.9%:10 ml intravenously every shift for line maintenance and before and after medication administration, and monitoring for the signs and symptoms of complications from the IV therapy for the 3 -11 shifts on 7/18, 7/19, and 7/26/25, and for the 11-7 shifts on 7/24, 7/25, 7/29, and 7/31/25.<br><br>- No measurements were documented for the midline external catheter length and arm circumference on 7/15, 7/22, and 8/29/25.<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 5's IV Administration Report for August 2025 showed the following:<br><br>- Missing documentation for the monitoring for signs and symptoms of complications and adverse reactions for the 7-3 shifts on 8/2, 8/3, and 8/4/25.<br><br>- No measurements were documented for the midline external catheter length and arm circumference on 8/5/25.<br><br>- Missing documentation for the normal saline flush for the 7–3 shifts on 8/2 and 8/3/25.<br><br>On 8/5/25 at 0930 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 5's midline dressing was undated. RN 1 stated he flushed the resident's midline earlier in the morning and did not notice the missing date on the midline dressing. RN 1 acknowledged the midline dressing should be dated and the label. RN 1 verified the above findings.<br><br>On 8/5/25 at 0945 hours, a follow up interview and concurrent medical record review was conducted with RN 1. When asked about the resident's midline care, external catheter length and arm circumference measurements, RN 1 stated the licensed nurse had measured the midline's external catheter length but did not document the actual measurements on the resident's medical record. RN 1 acknowledged the actual measurements for the external catheter length and arm circumference should have been documented to monitor for any shifting of the midline. When RN 1 was asked regarding Resident 5's midline maintenance for July and August 2025, which included the normal saline flushes, site checks, and antibiotic administration, RN 1 stated the licensed nurses should have documented the midline maintenance and IV medication administration on the resident's IV MAR. RN 1 stated if the resident refused the treatment/ medication or if there were any issues regarding the midline maintenance and IV antibiotic administration, then it should have been documented in the resident's progress notes. RN 1 acknowledged the missing documentation listed above and was unable to provide supporting documentation. RN 1 verified the above findings.<br><br>4. Medical record review for Resident 3 was initiated on 8/6/25. Resident 3 was admitted to the facility on [DATE].<br><br>On 8/6/2025 at 1117 hours, an observation and concurrent interview for Resident 3 was conducted with LVN 1. LVN 1 was asked at Resident 3's bedside about the resident's IV access. LVN 1 donned disposable gloves and asked Resident 3 to check his IV access and Resident 3 agreed. LVN 1 was then observed lifting Resident 3's clothing and exposing the resident's chest. Resident 3 was observed with a two-lumen central line on the left upper chest with dry dressing. LVN 1 stated the central line on the left upper chest was the resident's PICC line.<br><br>Review of Resident 3's Order Summary Report dated 8/5/25. showed the following physician's orders:<br><br>- dated 8/1/25, to administer piperacillin (antibiotic) solution reconstituted 3.375 gm intravenously every 12 hours for wound infection.<br><br>- dated 7/30/25, to measure the external catheter length of PICC line and measure arm circumference upon admission and every seven day(s) for site maintenance and as needed.<br><br>- dated 7/30/25, to change the PICC line transparent dressing per sterile technique upon admission<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and every day shift every seven day(s) for site maintenance as needed.<br><br>However, further review of Resident 3's Order Summary Report for August 2025 failed to show for a physician's order for the IV central line, care, maintenance, and monitoring.<br><br>On 8/6/25 at 1112 hours, an interview for Resident 3 was conducted with LVN 5. LVN 5 stated Resident 3 was on an IV antibiotic medication for the foot wound infection. LVN 5 stated Resident 3 had an IV access to his left upper chest.<br><br>On 8/6/25 at 1335 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 was asked about Resident 3' IV antibiotic medication and IV access. RN 1 verified Resident 3 was on IV antibiotic medication for the wound infection. RN 1 was asked where Resident 3's IV access was located. RN 1 stated the resident's IV access was the PICC line on the left upper chest. When RN 1 was asked if the IV central line was placed from the acute care hospital, RN 1 verified the resident's central line was placed at the acute care hospital. RN 1 was asked for the documentation for the placement of the resident's central line. RN 1 accessed the resident's electronic medical record, verified and acknowledged there was no documentation for the IV access central line. RN 1 verified and acknowledged the physician's order for the resident's IV access site was incorrect and inaccurate.<br><br>On 8/11/25 at 1125 hours, an interview for Resident 3 was conducted with the DON. The DON was informed and verified the above findings.<br><br>Cross reference to F656, example # 1. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**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 one of two final sampled residents (Resident 1) reviewed for tracheostomy services, and four of five residents (Residents 8, 22, 69, and 85) reviewed for oxygen therapy. * The facility failed to ensure only qualified staff managed the resident's oxygen delivery equipment. The SSD was observed turning Resident 1's oxygen concentrator off and on, in an attempt to troubleshoot a potential malfunction. * The facility failed to follow the physician's order for the administration of continuous oxygen for Resident 8. Resident 8 had an order to receive continuous oxygen at three LPM, however, Resident 8 received continuous oxygen at a rate of four LPM. * The facility failed to ensure Resident 22's nasal cannula tubing was dated and remained off of the floor. * The facility failed to document on the resident's MAR the administration of the oxygen to Resident 69. * The facility failed to obtain a physician's' order for the administration of continuous oxygen to Resident 85. These failures had the potential to result in negative resident health outcomes. Findings:<br><br>Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. Oxygen is administered under the orders of a physician.<br><br>1. Medical record review for Resident 1 was initiated on 8/5/25. Resident 1 was admitted to the facility on [DATE].<br><br>Review of Resident 1's physician's order dated 5/25/25, showed to administer oxygen via tracheostomy collar, at a rate of five LPM, may titrate the oxygen to maintain the oxygen saturation greater or equal to 92%.<br><br>Review of Resident 1's Care Plan Report revised 5/22/25, showed Resident 1 had altered respiratory status and was at risk for difficulty breathing related to tracheostomy, CHF, and chronic respiratory failure. The interventions included administering the oxygen at a rate of five LPM via tracheostomy.<br><br>On 8/6/25 at 1110 hours, an observation and concurrent interview was conducted with the SSD. The SSD was observed in Resident 1's room turning Resident 1's oxygen concentrator off and on. The SSD was asked what he was doing, to which he replied, the machine was beeping, so I turned it off and on. The SSD was asked if he had the training specific to managing the oxygen concentrator functionality, to which he replied, no. The SSD was asked if he should turn the oxygen concentrator off and on, to which he replied, no, I should have contacted the nurse. Resident 1 was then observed motioning with his hand and indicating he needed to be suctioned. This observer then contacted the DON.<br><br>On 8/6/25 at 1123 hours, an observation and concurrent interview was conducted with the DON. The DON entered Resident 1's room and performed the suctioning for Resident 1. The DON was informed the SSD was observed in Resident 1's room having turned Resident 1's oxygen concentrator off and on. The DON stated the SSD's action was not within the SSD's scope of practice. The DON stated the SSD having turned off the oxygen concentrator could result in negative health outcomes for Resident 1.<br><br>Cross Reference F940, example # 1.<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Medical record review for Resident 8 was initiated on 8/5/25. Resident 8 was admitted to the facility on [DATE].<br><br>Review of Resident 8's physician's order dated 12/17/24, showed an order to administer continuous oxygen via nasal cannula at a rate of three LPM.<br><br>Review of Resident 8's care plan titled Risk for Difficulty Breathing, End Stage CHF revised 1/8/25, showed to administer the oxygen via nasal canula as ordered.<br><br>On 8/5/25 at 0900 hours, an observation and concurrent interview was conducted with Resident 8. Resident 8 was observed lying in bed and receiving continuous oxygen via a nasal cannula, at a rate of four LPM. Resident 8 stated the licensed nurses at the facility had set the rate of her oxygen.<br><br>On 8/5/25 at 0952 hours, an observation, interview, and concurrent medical record review was conducted with LVN 2. Resident 8 was observed lying in bed and receiving continuous oxygen via a nasal cannula, at a rate of four LPM. LVN 2 was observed having obtained Resident 8's oxygen saturation (while receiving oxygen at a rate of four liters per minute). Resident 8's oxygen saturation level was 99%. LVN 2 then reviewed Resident 8's current orders and verified Resident 8's physician's order showed to administer continuous oxygen via nasal cannula, at a rate of three LPM. LVN 2 then lowered Resident 8's continuous oxygen to a rate of three LPM, in accordance with the physician's order. LVN 2 then obtained Resident 8's oxygen saturation (while receiving oxygen at a rate of three liters per minute). Resident 8's oxygen saturation level was 97%.<br><br>Cross reference F656 example #3.<br><br>3. Review of the facility's Medication Administration P&P dated 12/19/22, showed to sign the MAR after administering medication.<br><br>Medical record review for Resident 69 was initiated on 8/5/25. Resident 69 was admitted to the facility on [DATE].<br><br>Review of Resident 69 Order Summary Report showed a physician's order dated 7/9/25, for the oxygen to be administered at two LPM PRN, may titrate to maintain the oxygen saturation greater than or equal to 95%.<br><br>Review of Resident 69's progress notes showed the following:- dated 7/13/25 at 0325 hours, showed the oxygen was administered at two LPM via nasal cannula. - dated 7/14/25 at 1638 hours, showed the resident received the oxygen via nasal cannula.- dated 7/15/25 at 1620 hours, showed the resident received the oxygen via nasal cannula.- dated 7/17/25 at 1310 hours, showed the resident received the oxygen via nasal cannula.- dated 7/21/25 at 0233 hours, showed the resident received the oxygen via nasal cannula.- dated 7/21/25 at 1556 hours, showed the resident received the oxygen via nasal cannula.- dated 7/22/25 at 1505 hours, showed the resident received the oxygen via nasal cannula.- dated 7/23/25 at 1325 hours, showed the resident received the oxygen via nasal cannula.- dated 7/27/25 at 1245 hours, showed the resident received the oxygen via nasal cannula.- dated 7/28/25 at 1444 hours, showed the resident received the oxygen via nasal cannula.- dated 7/29/25 at 1340 hours, showed the resident received the oxygen via nasal cannula.- dated 7/31/25 at 1633 hours, showed the resident received the oxygen via nasal cannula.- dated 8/1/25 at 1400 hours, showed the resident received the oxygen via nasal cannula.- dated 8/2/25 at 1558 hours, showed the resident received the oxygen via nasal cannula.- dated 8/3/25 at 0710 hours, showed the resident (continued on next page) |

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| | 055622 | A. Building<br>B. Wing | 08/11/2025 |

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| Bonita Hills Post Acute | 1233 West LA Habra Boulevard<br>LA Habra, CA 90631 |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | was administered the oxygen via nasal cannula. - dated 8/5/25 at 1644 hours, showed the resident received the oxygen via nasal cannula.- dated 8/6/25 at 1638 hours, showed the oxygen was administered at two LPM via nasal cannula.<br><br>Review of Resident 69's MAR for July and August 2025, failed to show the oxygen was administered to the resident.<br><br>On 8/5/25 at 0921 hours, Resident 69 was observed lying in bed and receiving the oxygen via nasal cannula.<br><br>On 8/5/25 at 1500 hours, an observation and interview was conducted with LVN 2 at Resident 69's bedside. LVN 2 checked Resident 69's oxygen concentrator and stated the resident was on three LPM.<br><br>On 8/6/25 at 0801 hours, and on 8/7/25 at 0821 hours, Resident 69 was observed lying in bed and receiving the oxygen via nasal cannula.<br><br>On 8/7/25 at 1524 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 stated he was Resident 69's licensed nurse. LVN 3 stated the resident had been on oxygen all day, and was usually on oxygen. LVN 3 reviewed Resident 69's MAR for August 2025 and verified the record did not show the resident received the oxygen.<br><br>On 8/8/25 at 0903 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the oxygen administration should be documented in the residents' MAR. The DON stated Resident 69 had a PRN order for the oxygen and verified the resident's progress notes showed the resident was on oxygen on the above dates, however, the resident's MAR failed to show the oxygen was administered to the resident.<br><br>4. On 8/5/25 at 0835 hours, during the initial tour of the facility and at 1521 hours, an observation and concurrent interview for Resident 22 was conducted with LVN 5. Resident 22 was observed in bed awake with the oxygen on via nasal cannula, which attached to the oxygen concentrator machine and the rate set at two LPM. The nasal cannula was unlabeled and undated. In addition, the oxygen tubing was observed touching the floor. LVN 5 verified and acknowledged Resident 22's oxygen tubing was unlabeled and touching the floor. LVN 5 stated the oxygen tubing should have been labeled and kept off the floor. LVN 5 stated she would change the resident's oxygen tubing.<br><br>Medical record review for Resident 22 was initiated on 8/5/25. Resident 22 was admitted to the facility on [DATE].<br><br>Review of Resident 22's Order Summary Report dated 8/5/25, showed a physician's order dated 7/14/25, to administer the oxygen via nasal cannula at two LPM.<br><br>On 8/11/25 at 1139 hours, an interview for Resident 22 was conducted with the DON. The DON was informed and verified the above findings.<br><br>5. Review of the facility's P&P titled Oxygen Administration revised 5/20/24, showed oxygen was administered under the orders of a physician, except in the case of an emergency. The resident's care plan shall identify the interventions for oxygen therapy, based upon the residents assessment and orders such as, but not limited to:<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | a. The type of oxygen delivery system.<br><br>b. When to administer, such as continuous or intermittent and/or when to discontinue.<br><br>c. Equipment setting for the prescribed flow rates.<br><br>d. Monitoring of SpO2 (oxygen saturation) levels and/or vital signs, as ordered.<br><br>e. Monitoring for complications associated with the use of oxygen.<br><br>On 8/5/25 at 0914 hours, an interview and concurrent observation was conducted with Resident 85. Resident 85 was observed in bed receiving the oxygen via the nasal canula at 1.5 LPM. Resident 85's nasal canula tubing was not observed labeled with a date. Resident 85 stated she was administered the continuous oxygen via nasal cannula for about four to five days.<br><br>Medical record review for Resident 85 was initiated on 8/5/25. Resident 85 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 85's H&P examination dated 7/26/25, showed Resident 85 had the capacity to understand and make decisions.<br><br>Review of Resident 85's Order Summary Report dated 8/5/25, failed to show a physician's order for the administration of the oxygen via nasal canula.<br><br>Review of Resident 85's plan of care failed to show a care plan problem addressing Resident 85's use of the oxygen via nasal canula.<br><br>On 8/5/25 at 1504 hours, Resident 85 was observed sitting in her wheelchair and receiving the oxygen via nasal cannula at two LPM.<br><br>On 8/5/25 at 1532 hours, an observation, interview and concurrent medical record review for Resident 85 was conducted with RN 1. RN 1 stated there should be a physician's order for the administration of the oxygen. RN 1 stated the oxygen tubing should be changed weekly and labeled with the date. RN 1 stated Resident 85 had been on continuous oxygen via nasal cannula for a few days. RN 1 reviewed Resident 85's medical record and verified the above findings. RN 1 was observed at Resident 85's bedside and verified Resident 85 was receiving oxygen via the nasal cannula at two LPM. RN 1 verified the nasal canula tubing was not dated.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**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 the appropriate pain management was provided for three of three final sampled residents (Residents 10, 59, and 85) reviewed for pain management. * The facility failed to administer the pain medication according to the physician's order and failed to ensure the non-pharmacological pain interventions were implemented prior to the administration of the PRN pain medications for Resident 59. * The facility failed to ensure the non-pharmacological pain interventions were implemented and documented prior to the administration of the PRN pain medications to Residents 10 and 85. These failures had the potential to put Residents 10, 59, and 85 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication.Findings:<br><br>Review of the facility's P&P titled Pain Management revised 3/17/25, showed based upon the pain evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain. Non-pharmacological interventions will include but are not limited to: a. Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning), b. Loosening any constrictive bandage, clothing or device, c. Applying splinting (e.g., pillow or folded blanket), d. Physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning), e. Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility, f. Cognitive/behavioral interventions (e.g., music, relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and education about pain). Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain.<br><br>1. Medical record review for Resident 59 was initiated on 8/5/25. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's Plan of Care showed a care plan problem dated 7/29/25, addressing Resident 59's risk for pain related to his disease process. The interventions included to administer the analgesia as per the physician's orders.<br><br>Review of Resident 59's Order Summary Report dated 8/6/25, showed the following physician's orders:<br><br>- dated 7/10/25, to administer oxycodone (narcotic pain medication) 5 mg one tablet by mouth every four hours as needed for moderate pain (pain level of four to six, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst), and<br><br>-dated 7/10/25, to administer oxycodone10 mg one tablet by mouth every four hours as needed for severe back pain (pain level of eight to 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst).<br><br>Review of Resident 59's MAR for 7/2025 and 8/2025 showed Resident 59 was administered the PRN pain medications on the following dates and times, and for the following documented pain levels, (continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | outside of the ordered pain parameters:<br><br>* For the oxycodone 5 mg one tablet every four hours as needed for moderate pain (pain level of 4 to 6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst)<br><br>- on 7/12/25 at 2026 hours, for a pain level of 7.<br><br>- on 7/14/25 at 2016 hours, for a pain level of 7.<br><br>- on 7/15/25 at 2018 hours, for a pain level of 8.<br><br>- on 7/19/25 at 1715 hours, for a pain level of 7<br><br>* For the oxycodone 10 mg one tablet every four hours as needed for severe pain (pain level of 8 to 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst)<br><br>- on 7/13/25 at 1630 and 2100 hours, for a pain level of 7.<br><br>- on 7/14/25 at 0440 hours, for a pain level of 7.<br><br>- on 7/30/25 at 0638 and 2233 hours, for a pain level of 7.<br><br>- on 8/6/25 at 1302 hours, for a pain level of 7.<br><br>- on 8/7/25 at 0839 hours, for a pain level of 7.<br><br>Additionally, review of Resident 59's medial record failed to show documentation of the non-pharmacological pain interventions were implemented and its effectiveness prior to the administration of the oxycodone 5 mg or 10 mg PRN pain medications for the above dates and times.<br><br>On 8/7/25 at 1428 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 4. LVN 4 verified the above findings. LVN 4 stated the PRN pain medications should be administered as per the physician's order for the ordered pain parameters. LVN 4 stated Resident 59 did not have a physician's order for the pain medication for a pain level of seven of 10. LVN 4 further stated the physician's order for the PRN pain medications should have been clarified with the physician. LVN 4 further reviewed Resident 59's medical record and stated there was no documentation the non-pharmacological interventions for pain were implemented and its effectiveness prior to the administration of PRN pain medications for the above dates.<br><br>2. Medical record review of Resident 85 was initiated on 8/5/25. Resident 85 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 85's Order Summary Report dated 8/5/25, showed a physician's order dated 7/24/25, to administer hydrocodone-acetaminophen (a controlled pain medication) 5-325 mg, one tablet every six hours PRN for moderate (pain level 4 to 6, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst ) to severe (pain level of 7 to 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) pain.<br><br>Review of Resident 85' s MAR for 7/2025 and 8/2025 showed the hydrocodone-acetaminophen 5-325<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | mg pain medication was administered to Resident 85 on the following dates and times:<br><br>- on 7/26/25 at 1208 hours,<br><br>- on 7/27/25 at 1152 hours,<br><br>- on 7/28/25 at 1627 hours,<br><br>- on 7/29/25 at 2014 hours,<br><br>- on 7/31/25 at 2023 hours<br><br>- on 8/1/25 at 2021 hours, and<br><br>- on 8/4/25 at 2003 hours.<br><br>Review of Resident 85's medial record failed to show documentation the non-pharmacological interventions for pain were implemented and its effectiveness prior to the administration of the hydrocodone-acetaminophen 5-325 mg pain medication for the above dates and times.<br><br>On 8/7/25 at 1343 hours, an interview and concurrent medical record review for Resident 85 was conducted with LVN 4. LVN 4 reviewed Resident 85's medical record and verified the above findings. LVN 4 stated the nonpharmacological pain interventions were not documented and should be documented in the nurse's progress notes.<br><br>On 8/11/25 at 0841 hours, an interview was conducted with the DON. The DON stated when the resident complained of pain, the licensed nurse should assess the resident's pain and should implement the non-pharmacological pain interventions. The DON stated if the non-pharmacological interventions for pain were ineffective then the licensed nurse should administer the PRN pain medications as ordered by the physician. The DON further stated if the non-pharmacological interventions for pain were effective, then the pharmacological intervention would not be needed. The DON stated, the non-pharmacological interventions implemented should be documented in the MAR and if the licensed nurses were not able to document in the MAR, the licensed nurse should document the non-pharmacological interventions in the progress notes.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.<br><br>3. Medical record review for Resident 10 was initiated on 8/5/25. Resident 10 was readmitted to the facility on [DATE].<br><br>Review of Resident 10's Order Summary Report showed a physician's order dated 6/11/25, for hydrocodone-acetaminophen (a controlled pain medication) 5-325 mg, to be administered every six hours PRN for moderate to severe pain.<br><br>Review of Resident 10's MAR for August 2025 showed the hydrocodone-acetaminophen medication was administered to the resident on 8/2/25 at 2121 hours, and 8/4/25 at 0936 hours.<br>(continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 10's medical record failed to show the non-pharmacological interventions were attempted prior to administering the hydrocodone-acetaminophen medication.<br><br>On 8/7/25 at 1442 hours, an interview and concurrent record review for Resident 10 was conducted with the DON. The DON reviewed Resident 10's MAR for 8/2025 and verified the resident received the hydrocodone-acetaminophen medication twice for moderate to severe pain. The DON stated the non-pharmacological interventions should be attempted prior to administering the PRN pain medications and verified Resident 10's medical record failed to show non-pharmacological interventions were attempted prior to administering the hydrocodone-acetaminophen medication to the resident. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>**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 the dialysis care was provided for one of three final sampled residents (Resident 28) reviewed for dialysis. * The facility failed to ensure a physician's order for the peritoneal dialysis was obtained including the care of the dialysis access site of Resident 28. These failures had the potential for medical complications related to not obtaining the physician's order for dialysis care.Findings: Review of the facility's P&P titled Peritoneal Dialysis dated 12/19/22, showed the physician's order for the individualized prescriptions must include at least the number of exchanges or cycles to be done during each dialysis session, the volume of fluid with each exchange, duration of fluid in the peritoneal cavity, the concentration of glucose or other osmotic agent to be used for fluid removal, and the use of automated, manual or combined techniques. Before, during and after receiving the peritoneal dialysis, the facility staff must, based on the physician's orders and professional standards of practice, do the following: obtain vital signs, weights, assess the resident's stability, level of consciousness, and comfort or distress; monitor for post-dialysis complications and symptoms such as, but not limited to dizziness, nausea, fatigue, or hypotension; report identified or suspected complications immediately to the attending physician and dialysis staff to enable timely interventions; documentation of ongoing evaluation of the peritoneal catheter, including assessment of catheter related infections and tunnel for condition, monitoring for patency, leaks, infection, and bleeding at the site; and monitor for complications such as peritonitis. On 8/5/2025 at 0909 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 28. Resident 28 was observed awake on his left side position in bed. A dialysate bag was observed hung on the IV pole infusing via gravity connected to Resident 28's peritoneal dialysis access site on the abdomen, and the drainage bag was on the floor with a towel underneath. Resident 28 stated his dialysis was ongoing and doing it two times a day everyday in the morning and in the afternoon for approximately three to four hours. Medical record review for Resident 28 was initiated on 8/5/25. Resident 28 was admitted to the facility on [DATE], with the diagnosis of End Stage Renal Disease and dependence on dialysis. Review of Resident 28's Order Summary Report for 8/2025 failed to show a physician's order for peritoneal dialysis at the bedside, including the assessment of the peritoneal dialysis access site before, during, and after dialysis. Further review of Resident 28's medical record failed to show documented evidence of Resident 28's assessment before, during, and after dialysis. On 8/6/2025 at 1335 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 1. RN 1 was asked about Resident 28's peritoneal dialysis. RN 1 verified Resident 28 had peritoneal dialysis. RN 1 stated there was a kit for peritoneal dialysis which with the dialysate and the drainage bag. RN 1 stated and verified the peritoneal dialysis was given to Resident 28 two times a day, everyday. RN 1 was asked about the physician's order for administering the peritoneal dialysis to Resident 28. RN 1 accessed Resident 28's electronic medical record, verified and acknowledged there was no physician's order for the peritoneal dialysis. When RN 1 was asked about the documentation for the ongoing peritoneal catheter care monitoring and assessment, RN 1 was not able to show any documentation. On 8/11/2025 at 1139 hours, an interview was conducted with the DON. The DON was informed and verified the above findings. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**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 accurate controlled medication records for one nonsampled resident (Resident 87). * Resident 87's MAR for October and November 2024 failed to show the Oxycodone/APAP (a controlled pain medication) documented on the Antibiotic or Controlled Drug Record were administered to the resident when the medication was removed from the medication supply. This failure resulted in inaccurate accounting of a controlled medication and the potential for drug diversion. Findings: Closed medical record review for Resident 87 was initiated on 8/8/25. Resident 87 was readmitted to the facility on [DATE], and discharged on 11/25/24. Review of Resident 87's Antibiotic or Controlled Drug Record for Oxycodone/APAP (a controlled pain medication) 5-325 mg tablets initiated on 10/28/24 at 1853 hours, showed the following:- On 10/31/25 at 1330 hours, one tablet was removed from the medication supply.- On 11/4/24 at 1030 hours, one tablet was removed from the medication supply.- On 11/22/24 at 0811 hours, one tablet was removed from the medication supply.- On 11/22/24 at 0900 hours, one tablet was removed from the medication supply. Review of Resident 87's MARs for October and November 2024 failed to show documentation if the above tablets were administered to the resident to account for why the tablets were removed from the medication supply. On 8/8/25 at 1011hours, an interview and concurrent closed medical record review for Resident 87 was conducted with the DON. The DON verified the above findings. The DON stated when the controlled medications were removed from the supply, they should be documented on the Antibiotic or Controlled Drug Record and on the MAR to show it was administered to the resident. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**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 ensure the consultant pharmacist performed a monthly Medication Regimen Review to identify potential medication irregularities for two of five sampled residents (final sampled residents, Residents 28 and 65) reviewed for unnecessary medications. * The facility failed to ensure the Medication Regimen Review conducted by the consultant pharmacist in June and July 2025 for Resident 65 addressed the use of two antidepressant medications (mirtazapine and trazodone) and antipsychotic medication (Risperidone). *The facility failed to ensure the Medication Regimen Review conducted by the consultant pharmacist for July 2025 for Resident 28 addressed the irregularities and inaccurate monitoring of the poor meal intake of less than 50% of his meals, as ordered by the physician. These failures placed the residents at risk for adverse outcomes related to the medications they were receiving.Findings:<br><br>Review of the facility's P&P titled Medication (Drug) Regimen Review (MRR) dated 6/2021 showed the consultant pharmacist is required to perform a comprehensive Medication Regimen Review at least monthly. The Medication Regimen Review includes evaluating the resident's response to medication therapy to ensure the resident maintains the highest practicable level of functioning and to prevent or minimize adverse consequences related to medication therapy.<br><br>1. Medical record for Resident 65 was initiated on 8/5/25. Resident 65 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 65's Order Summary Report dated 8/6/25, showed physician's order dated:<br><br>-5/13/25, for risperidone (antipsychotic) oral tablet 0.5 mg give by mouth two times a day for Schizophrenia manifested by auditory hallucinations, hearing voices. On hold from 7/17 to 7/20/25;<br><br>-5/13/25, for risperidone oral tablet 1 mg give one tablet by mouth at bedtime for Schizophrenia manifested by auditory hallucination, hearing voices. On hold from 7/17 to 7/20/25;<br><br>-6/20/25, for trazodone (antidepressant) HCL tablet 100 mg give one tablet by mouth at bedtime related to depression, unspecified manifested by inability to sleep. On hold from 7/17 to 7/20/25; and<br><br>-6/30/25, for mirtazapine (antidepressant) tablet 7.5 mg give one tablet by mouth at bedtime for depression manifested by poor PO intake. On hold from 7/17 to 7/20/25<br><br>Review of the facility's June and July 2025 Medication Regimen Review Current Resident Listings showed a list of the residents whose medication regimens were reviewed by the consultant pharmacist. However, review of the facility's Medication Regimen Review binder failed to show the consultant pharmacist conducted a Medication Regimen Review for Resident 65 to include the use of the psychotropic medications for June and July 2025.<br><br>On 7/25/25 at 1030 hours, an interview and concurrent medical record review for Resident 65 was conducted with the DON. The DON stated that the consultant pharmacist was expected to conduct a Medication Regimen Review for all the residents at the facility every month. The DON verified Resident 65 should have had a Medication Regimen Review conducted by the consultant pharmacist (continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | for June 2025 and July 2025, specifically for the use of the psychotropic medications which included Trazodone, Risperidone, and Remeron. The DON confirmed the findings.<br><br>2. Medical record review for Resident 28 was initiated on 8/5/25. Resident 28 was admitted to the facility on [DATE], with a diagnosis of depression.<br><br>Review of Resident 28's Order Summary Report dated 8/7/25, showed a physician's order dated 6/3/25, and discontinued on 8/6/25, to administer mirtazapine 0.5 mg tablet by mouth at bedtime for depression manifested by poor intake less than 50% of each meal. Another physician's order dated 6/3/25, showed to monitor poor intake less than 50% of meals and record the number of times the behavior was manifested every shift.<br><br>Review of Resident 28's Nutrition Amount Eaten record for the last 30 days dated 7/10, 7/11, 7/18, 7/22, 7/26, 7/27, 7/28, 8/2, 8/4, and 8/5/25, showed Resident 28 consumed less than 50% of his meals.<br><br>Review of Resident 28's Monitor Record from 7/1 through 7/31/25, for the monitoring of poor intake less than 50% of meals, showed zero number of times the behavior manifested every shift. The information documented on the Monitor Record was inconsistent with the information documented on the Nutrition Amount Eaten, on the specified dates.<br><br>Further review of Resident 28's medical record failed to show evidence of the monthly behavior monitoring summary was completed.<br><br>Review of Resident 28's consultant pharmacist's Medication Regimen Review for July 2025 showed no recommendation or any irregularities. However, the review of Resident 28's medical record showed documentation of irregularities and inaccurate monitoring of the poor intake of less than 50% of Resident 28's meals, as a behavior manifestation for the use of the antidepressant medication.<br><br>On 8/7/2025 at 1043 hours, an interview and concurrent medical record review for Resident 28 was conducted with RN 1. RN 1 verified and acknowledged Resident 28 was on antidepressant medication and was monitored for poor intake less than 50%. RN 1 was asked on who determined the meal percentage of Resident 28 and stated the CNAs recorded the meal percentage on the meal percentage record. RN 1 was able to show the meal percentage record of the resident for the past 30 days and verified there were episodes the resident had less than 50% meal percentage. RN 1 was asked about the monitoring of the behavior of the resident. RN 1 was able to show the monitoring of behavior for July 2025 and verified there was zero behavior documented of poor intake less than 50%. RN 1 verified and acknowledged the monitoring of the behavior for poor intake was inaccurate. RN 1 was asked if there was a monthly summary of behavior documented for Resident 28's poor intake for the past months. RN 1 reviewed Resident 28's medical record and verified there was no monthly summary of behavior documented and completed.<br><br>On 8/7/2025 at 1125 hours, an interview and concurrent medical record review for Resident 28 was conducted with the DON. The DON was asked about the resident's antipsychotic medications. The DON stated they monitored the resident and made sure the medication was being given to the resident, and the behavior was being monitored. The DON was informed of the irregularities about the medication monitoring of Resident 28 for the use of mirtazapine medication, and of inconsistent and inaccurate monitoring for the behavior of poor intake of the resident. The DON was also informed of the monthly summary not completed and the consultant pharmacist Medication Regimen Review for<br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the past month did not identify any irregularities. The DON verified and acknowledged the monitoring behavior of poor intake was inaccurate and there was no monthly summary of the resident's behavior.<br><br>Cross reference F605, example # 3. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**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 one of 21 final sampled residents (Resident 59) was free from the unnecessary medications. * The facility failed to follow the physician's order to hold the metoprolol (blood pressure medication) medication when Resident 59's SBP (Systolic Blood Pressure) was less than 120 mmHg. This failure had the potential for Resident 59 to develop significant adverse and side effects from the medication. Findings: Review of the facility's P&P titled Medication Administration revised 12/19/22, showed the medications were administered by the licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. Further review of the P&P showed to obtain and record the vital signs, when applicable or per the physician's orders. When applicable, hold the medication for those vital signs outside the physician's prescribed parameters. To administer the medication as ordered in accordance with manufacturer specifications and sign the MAR after the administration. For those medications requiring vital signs, to record the vital signs onto the MAR. Medical record review for Resident 59 was initiated on 8/5/25. Resident 59 was admitted to the facility on [DATE]. Review of Resident 59's plan of care showed a care plan problem dated 7/17/25, addressing Resident 59's risk for complications related to hypertension. The interventions included to administer the anti-hypertensive medications as ordered and to observed the blood pressure and/or pulse monitoring parameters prior to the medication administration. Review of Resident 59's Order Summary Report dated 8/6/25, showed a physician's order dated 7/22/25, to administered metoprolol 25 mg one tablet by mouth every 12 hours for hypertension (high blood pressure) and to hold if the SBP was less than 120 mmHg or the heart rate was less than 60 beats per minute. Review of Resident 59's MAR for August 2025 showed Resident 59 was administered the metoprolol 25 mg medication on the following dates and times when Resident 59's SBP was less than 120 mmHg:- On 8/1/25 at 2100 hours, when Resident 59's SBP was 118/60 mmHg;- On 8/2/25 at 2100 hours, when Resident 59's SBP was 110/68 mmHg;- On 8/3/25 at 2100 hours, when Resident 59's SBP was 118/72 mmHg; and - On 8/5/25 at 0900 hours, when Resident 59's SBP was 116/75 mmHg; and at 2100 hours, when Resident 59's SBP was 118/66 mmHg. On 8/7/25 at 1428 hours, an interview and concurrent medical record review for Resident 59 was conducted with LVN 4. LVN 4 stated Resident 59 had the diagnosis of hypertension and was administered the blood pressure (BP) medications. LVN 4 stated when administering the BP medications, the resident's BP and heart rate were obtained prior to administering the BP medication. LVN 4 stated if the BP reading and heart rate were within the parameters ordered by the physician, the BP medication would be administered. LVN 4 stated a checkmark in the MAR indicated the medication was administered to the resident. LVN 4 reviewed Resident 59's MAR for August 2025 and verified the above findings. LVN 4 stated the metoprolol medication should have been held as per the physician's order. On 8/11/25 at 0841 hours, an interview was conducted with the DON. The DON stated for the administration of the BP medications with ordered parameters, the licensed nurses were expected to take the appropriate vital signs and compare the vital signs with the ordered parameters prior to the administration of the medication. The DON stated the checkmarks on the MAR meant the licensed nurse had documented the licensed nurse administered the medication to the resident. On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**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%. The facility's medication error rate was 29.63%. Two of three licensed nurses (LVNs 3 and 5) were found to have made errors during the medication administration observations. * LVN 3 failed to administer the complete dose for six of Resident 2's medications when significant residual of the medications were observed in the medication cups and nebulizer cup. In addition, LVN 3 combined two GT medications and failed to administer the two medications as per the physician's order. * LVN 5 failed to obtain Resident 33's heart rate prior to the administration of the carvedilol (blood pressure medication). These failures had the potential to negatively affect the residents' health.Findings: Review of the facility's P&P titled Medication Administration revised 12/19/22, showed the medications were administered by the licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. Further review of the P&P showed to obtain and record vital signs, when applicable or per the physician's orders. When applicable, hold the medication for those vital signs outside the physician's prescribed parameters. To review the MAR to identify the medication to be administered and to compare the medication source (bubble pack, vial, etc.) with the MAR to verify the resident name, medication name, form, dose, route, and time. 1. On 8/6/25 at 0800 hours, a medication administration observation for Resident 2 was conducted with LVN 3. LVN 3 prepared and administered the following medications to Resident 2:- one packet of Juven (wound healing supplement) mixed in six-ounces of water;- one tablet of vitamin C (supplement) 500 mg;- two tablets of docusate sodium (stool softener) 100 mg;- one table of simethicone (gas relief) 125 mg;- 30 ml of LiquaCel (liquid protein);- 5 ml of Multivite Liquid (supplement);- 17 gm of polyethylene glycol (laxative) powder 3350;- one vial of budesonide (inhaled corticosteroid used to manage and prevent symptoms like difficulty breathing, chest tightness, wheezing, and coughing associated with asthma) inhalation suspension 0.5 mg/2 ml; and- 1 ml of heparin (anticoagulant) 5000 units. During the medication administration observation for Resident 2, LVN 3 was observed pouring the MultiVite liquid medication into the irrigation syringe. LVN 3 was then observed adding the polyethylene glycol mixture to the MultiVite liquid medication before it was fully administered through the GT. After the administration of the GT medications, the following was observed:- three medication cups with significant white-colored medication residue;- one medication cup with brown-colored liquid; and- one cup with orange-colored powder mixture remaining in the cup. On 8/6/25 at 0844 hours, an interview and concurrent observation was conducted with LVN 3. LVN 3 verified the above findings. LVN 3 identified the above medications were the Juven, LiquCel, docusate sodium, simethicone, and vitamin C. LVN 3 stated for the administration of the medications through the GT, the medication should be administered via gravity and flushed in between each medication. LVN 3 stated each medication should be completely administered before adding the next medication. On 8/6/25 at 0851 hours, an interview and concurrent observation was conducted of LVN 3. LVN 3 was observed removing Resident 2's nebulizer mask and placing the nebulizer set up inside the clear bag. LVN 3 was not observed checking the nebulizer cup to ensure there was no medication left in the nebulizer cup. When asked, LVN 3 verified he did not check the nebulizer cup to see if the complete dose was administered. An observation of the nebulizer cup was conducted with LVN 3. LVN 3 verified there was medication left inside the nebulizer cup. LVN 3 stated if there was still medication observed in the nebulizer cup, he should continue the breathing treatment until the dose was completely administered. Review of Resident 2's Order Summary Report dated 8/6/25, showed the following physician's orders dated 6/6/25:- to administer simethicone 80 mg via GT three times a day for gastroesophageal reflux disease (chronic digestive disorder where stomach acid frequently flows back into the esophagus). However, LVN 3 was observed administering simethicone 125 mg to Resident 2 during the medication administration observation.- to administer polyethylene glycol<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | powder 1450 17 gm via GT one time a day for bowel management. However, LVN 3 was observed administering polyethylene glycol powder 3350 to Resident 2 during the medication administration observation. On 8/6/25 at 1108 hours, a follow-up interview and concurrent medical record review for Resident 2 was conducted with LVN 3. LVN 3 reviewed the physician's order and verified he administered the wrong doses for the simethicone and polyethylene glycol powder medications. When asked, LVN 3 stated he did not have the simethicone medication 80 mg in his medication cart. On 8/6/25 at 1135 hours, an interview and concurrent observation was conducted with LVN 5. LVN 5 stated she did not have the simethicone medication 80 mg in her medication cart. On 8/6/25 at 1140 hours, an interview and concurrent observation was conducted of Medication Cart A and Medication Room A with LVN 6. LVN 6 stated she did not have the simethicone medication 80 mg in her medication cart and stated Medication Room B only had the simethicone 125 mg medication bottles available. On 8/6/25 at 1145 hours an interview was conducted with the DON. The DON stated the over-the-counter facility stock supply of medications were all kept inside Medication Room B. 2. On 8/6/25 at 0902 hours, a medication administration observation was conducted for Resident 33 with LVN 5. LVN 5 obtained Resident 33's blood pressure reading, then prepared and administered the following medications to Resident 33:- one tablet of carvedilol (blood pressure medication) 12.5 mg;- one tablet of valsartan (blood pressure medication) 320 mg;- one tablet of spironolactone (diuretic medication) 100 mg;- one tablet of chlorthalidone (diuretic and blood pressure medication) 25 mg;- one tablet of amlodipine (blood pressure medication) 10 mg;- one tablet of Nephro-Vite (Vitamin supplement); and- one 4% lidocaine patch (pain reliever). Medical record review for Resident 33 was initiated on 8/6/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Order Summary Report dated 8/6/25, showed a physicians' order dated 7/23/25, to administer carvedilol 12.5 mg one tablet by mouth two times a day for hypertension. To hold if the SBP was less than 100 mmHg or the heart rate was less than 60 beats per minute. However, LVN 5 was not observed obtaining Resident 33's heart rate prior to the administration of the carvedilol medication. On 8/6/25 at 1018 hours, an interview and concurrent medical record review for Resident 33 was conducted with LVN 5. LVN 5 verified she did not check Resident 33's heart rate prior to the administration of the carvedilol medication. LVN 5 stated she went back to check Resident 33's heart rate after the administration of the carvedilol medication and Resident 33's heart rate was 70 beats per minute. On 8/11/25 at 0841 hours, an interview was conducted with the DON. The DON stated during the administration of the medication via the GT, if the licensed nurse observed residual medication in the medication cups, the licensed nurse should add more water, stir the content, and administer the complete dose of the medication. The DON stated for the administration of the medications, the licensed nurses were expected to compare the physician's order with the medication available on hand to ensure the medication, route and dose were correct. The DON stated the licensed nurses should review the ordered parameters and hold the medication if the ordered parameters were not met. On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and facility P&P review, the facility failed to ensure proper labeling and storage of the drugs and biologicals in a safe manner for one of one medication room (Medication Room B), and for three of three medication carts (Medication Carts A, B, and C) inspected.* The facility failed to ensure the 0.9% sodium chloride flush (a sterile solution used to maintain the patency of intravenous catheters and prevent complications) was not kept in Resident 59's room.* A bottle of Multivite (liquid supplement) and a bottle of LiquaCel (liquid protein) were observed with a sticky brown residue in Medication Cart B.* The facility failed to dispose of the expired medical supplies in Medication Room B.* The facility failed to dispose of expired medical supplies in Medication Cart C.* The facility failed to ensure proper storage of unopened insulin (medication to control blood glucose levels) pen stored at room temperature inside Medication Cart A. These failures had the potential for infection control concerns and for the residents to receive expired or deteriorated medications or biologicals. Findings: Review of the facility's P&P titled Medication Storage revised [DATE], showed all the drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. Review of the facility's P&P titled Medication Administration revised [DATE], showed medications were administered by the licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician. To keep the medication cart clean, organized, and stocked with adequate supplies. 1. On [DATE] at 0841 hours, during the initial tour of the facility, an opened 10-ml syringe of 0.9% sodium chloride was observed on top of the alcohol-based hand rub dispenser in Room A. On [DATE] at 0845 hours, an interview and concurrent observation of the10-ml syringe of 0.9% sodium chloride was conducted with RN 1. RN 1 stated the sodium chloride flushes for the IVs were stored individually sealed inside the IV carts. RN 1 verified the above findings and stated the sodium chloride flushes should not be kept at the resident's bedside or in the resident's rooms. RN 1 was observed removing and discarding the sodium chloride flush. 2. On [DATE] at 0800 hours, during the medication administration observation for Resident 2 with LVN 3, a bottle of Multivite and a bottle of LiquaCel were observed with a sticky brown colored residue on the bottles. LVN 3 verified the above findings and stated the licensed nurse assigned to the medication cart was responsible for cleaning the medication cart and ensuring the stains on the medication bottles were cleaned before placing the bottles back inside the medication cart. 3. On [DATE] at 1016 hours, during the inspection of Medication Room B with RN 1, the following was observed:- one 4- ml urine culture and sensitivity vacutainer (a brand name for a system used for collecting blood samples) labeled with the resident's name and date of birth ,- one 4-ml urine culture and sensitivity vacutainer with an expiration date of [DATE],- one 6-ml vacutainer with an expiration date of [DATE],- one culture swab with an expiration date of [DATE],- one culture swab with an expiration date of [DATE],- one blue ova and parasite stool specimen container with an expiration date of [DATE], and- one box containing multiple 3-ml syringes with a 23-gauge needle set with the expiration date of [DATE].RN 1 verified the above findings and stated the expired medical supplies should not be kept in the medication rooms. 4. On [DATE] at 1043 hours, during the inspection of Medication Cart C with RN 2, the following was observed:- a roll of Mefix-self-adhesive fabric tape with an expiration date of [DATE],- three 3-ml syringes with a 23-gauge needle set with an expiration date of [DATE],- one 3-ml syringe with a 23-gauge needle set with an expiration date of [DATE],- 15 packets of the 10% Povidone-Iodine (used to disinfect skin and wounds) Swab sticks with an expiration date of 3/2025, and- three Huber needle sets (used to access implanted ports) with an expiration date of [DATE].RN 2 verified the<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | above findings and stated the licensed nurse assigned to the medication cart was responsible for checking the cart at the beginning of the shift to ensure the IV medications were stored in the IV medication cart and the expired medical supplies were removed. 5. On [DATE] at 1112 hours, during the inspection of Medication Cart A with LVN 3, one unopened Lispro (insulin) 100 units/ml pen for Resident 50 was observed stored inside a clear bag. The label on the bag showed to refrigerate until used, and once in use, to store at room temperature. LVN 3 verified the above findings and stated he did not know how long the insulin pen had been in the medication cart. LVN 3 further stated the insulin pen should be stored inside the refrigerator until used. On [DATE] at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility document review, the facility failed to ensure one of five residents reviewed for dining (Resident 67) received food prepared in a form to meet the resident's individual dietary needs. * The facility failed to ensure Resident 67 was provided with a soft and bite-size texture diet. This failure had the potential to cause choking in a medically vulnerable resident. Findings: Review of the facility's document title Diet Count by Diet dated 8/5/25, showed there was five residents on a soft and bite sized (SB6) diet. Review of the IDDSI (International Diet Dysphagia Standardization Initiative- a global framework that standardizes the terminology and definitions used for texture-modified foods and thickened liquids for people with dysphagia) showed soft bite sized meats (SB6) should be no larger than 1.5 cm equivalent to 1/2 an inch.<br>https://www.iddsi.org/images/Publications-Resources/DetailedDefnTestMethods/English/V2DetailedDefnEngli<br>Medical record review for Resident 67 was initiated on 8/5/25. Resident 67 was admitted to the facility on [DATE], and had diagnoses of type 2 Diabetes Mellitus (a long-term condition in which the body has trouble controlling blood sugar) and dysphagia (difficulty swallowing). Review of Resident 67's physician's order dated 6/18/25, showed a regular diet with regular (RG7) texture, thin consistency per the ST (Speech Therapist), no raw vegetables, and to keep meat at SB6 texture. On 8/5/25 at 1307 hours, during the lunch observation in the dining room, Resident 67 was observed without a meal tray while her table mates were eating. Resident 67 stated she was waiting for a hot dog. Resident 67's lunch meal was served and consisted of a hot dog sliced in large chunks, approximately one inch by half an inch, a hot dog bun, chopped cooked carrots and chopped sweet potatoes. A picture was obtained of Resident 67's lunch meal. On 8/6/25 at 1350 hours, an interview and concurrent observation was conducted with the SLP. The SLP verified Resident 67 was on a regular diet with SB6 meats. The picture of Resident 67's lunch meal on 8/5/25, was shown to the SLP. The SLP verified the hot dog served to Resident 67 for the lunch meal was not SB6 texture. The SLP stated the hot dog should have been cut into smaller pieces, either in half or thinner slices. |

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| F 0813<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Have a policy regarding use and storage of foods brought to residents by family and other visitors.<br><br>Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the residents' food brought from outside sources was stored for future consumption. * The facility failed to provide refrigerated storage for the residents' food brought from outside sources. This failure had the potential to negatively impact all the residents who received an oral diet and resided in the facility. Findings: Review of the facility's matrix dated 8/5/25, showed 62 residents were on an oral diet. Review of the federal guidelines in the State Operations Manual S483.60(i)(3) showed the facility must have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. Review of the facility's P&P titled Outside Food Brought in by Family and Visitors revised 1/25/24, showed all the food items that are prepared by the family or visitor brought in must be approved per nursing to ensure it is in accordance with the Diet Order and eaten within two hours of receiving and all remaining food must be discarded. On 8/6/25 at 1423 hours, an interview was conducted with LVN 8. LVN 8 verified the food brought from the outside for the residents' consumption must be consumed within two hours and the facility did not provide refrigerated storage for the food brought from the outside. On 8/725 at 0930 hours, an interview was conducted with the RD. The RD verified the facility did not have a refrigerator to store the food brought by the visitors for the resident consumption. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Dispose of garbage and refuse properly.<br><br>Based on observation and interview, the facility failed to ensure the organic trash was disposed of properly. * The facility failed to separate the organic trash from their regular trash. This failure had the potential to increase the environmental impact of the facility, thus adversely impacting all the 71 residents' health who resided in the facility. Findings: Review of the Senate [NAME] 1383 regulation dated 1/1/22, showed every jurisdiction was to provide organic waste collection services to all residents and businesses. Jurisdiction includes city, county, city and county, or a special district that provides solid waste collection services. Organic waste includes food, green material, landscape and pruning waste, organic textiles and carpets, lumber, wood, paper products, printing and writing paper, manure, biosolids, digestate, and sludges. On 8/5/25 at 1515 hours, an observation of the outside trash dumpster area and concurrent interview was conducted with the DSS. The DSS stated the kitchen staff separated the organic food waste and discarded it in the organic trash bin. Two organic trash bins were observed behind the wall of the trash dumpster area. Both bins were empty, dry, and appeared unused. The DSS was asked where the kitchen staff discarded the organic food waste from the kitchen. The DSS verified the organic food waste was not separated from the regular trash and was discarded in the regular trash bin in the kitchen. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**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 implement the infection control practices designed to provide a safe and sanitary environment and prevent the transmission of diseases and infections for six of 21 final sampled residents (Residents 2, 3, 4, 46, 59, and 83). * The facility failed to ensure LVN 3 donned the gown during the medication administration observation for Resident 2. Resident 2 was on EBP (Enhanced Barrier Precaution) for her GT (Gastrostomy Tube). * CNA 8 failed to follow the EBP infection control practices while providing care to Resident 3. * LVN 6 failed to follow the EBP infection control practices while administering the GT enteral feeding for Resident 4. * LVN 1 failed to follow the infection control practices while performing the wound care for Resident 46. * The facility failed to implement the EBP as per the facility's P&P for Resident 59, who had a right upper arm PICC (Peripherally Inserted Central Catheter) line. * The facility failed to ensure Housekeeper 1 donned the gown before entering Resident 83's room and cleaning Resident 83's bedside table. Resident 83 was on EBP for her chronic wounds. These failures posed the risk for transmission of communicable diseases to the other residents in the facility. Findings:<br><br>Review of the facility's P&P titled Enhanced Barrier Precautions revised 3/10/25, showed it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. EBP are indicated for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.<br><br>1. On 8/5/25 at 0824 hours, Resident 59 was observed with a PICC line with two port external catheters on the right upper arm. The EBP sign outside of Resident 59's room was observed with a yellow sticker next to Bed A. A yellow sticker was not observed next to Bed B (Resident 59's bed).<br><br>Medical record review for Resident 59 was initiated on 8/5/25. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's progress note dated 7/9/25, showed Resident 59 was admitted to the facility with a PICC line, with two-lumens on the right upper arm.<br><br>Review of the facility's document titled Enhanced Barrier Precautions list as of 8/6/25, showed the EBP was not implemented for Resident 59.<br><br>Review of Resident 59's Order Summary Report showed a physician's order dated 8/6/25, to implement the EBP related to Resident 59's PICC line.<br><br>On 8/6/25 at 1324 hours, an interview and concurrent medical record review for Resident 59 was conducted with RN 2. RN 2 stated Resident 59 had a PICC line on the right upper arm and was currently receiving intravenous antibiotics. RN 2 stated Resident 59 should be on the EBP due to<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 59's PICC line. RN 2 stated a physician's order was required to implement the EBP. RN 2 reviewed Resident 59's medical record and stated she could not find a physician's order to implement the EBP related to Resident 59's PICC line prior to 8/6/25.<br><br>On 8/6/25 at 1409 hours, an interview was conducted with the IP. The IP stated every resident on the EBP should have a physician's order to implement the EBP. The IP stated the yellow sticker on the EBP signs outside of the residents' rooms indicated to the facility staff the residents who were on EBP. The IP stated for the residents who were on the EBP, the facility staff should don the appropriate PPEs, including the gown and gloves when in the resident's room and participating in the activities listed on the EBP sign. When asked about Resident 59's isolation status, the IP stated Resident 59 was on the EBP due to the administration of the TPN (Total Parenteral Nutrition). The IP stated Resident 59's physician's order for the EBP was discontinued when his TPN was discontinued. However, Resident 59 still had the PICC line on the right upper arm. The IP stated if a resident had a PICC line, the resident should be on the EBP. The IP stated he was not aware Resident 59 still had his PICC line.<br><br>2. On 8/5/25 at 0901 hours, an observation and concurrent interview was conducted with Housekeeper 1. A sign outside of Resident 83 showed to implement the EBP for Resident 83. The EBP sign showed the providers and facility staff must also wear gloves and a gown for the high contact resident care activities: activities of daily living, caring for devices (central line, urinary catheter, feeding tube, tracheostomy and giving medical treatment), toileting and changing incontinent briefs, wound care, mobility assistance, transferring and preparing to leave the room, and cleaning the environment. Housekeeper 1 was observed entering Resident 83's room and wiping Resident 83's bedside table. Housekeeper 1 was not observed wearing a gown. When Housekeeper 1 was asked, she stated the EBP sign outside of the resident's door informed her which residents she should implement the EBP for. Housekeeper 1 stated Resident 83 was on EBP, which meant she should don the gown and gloves when touching or cleaning Resident 83's surroundings. Housekeeper 1 verified she did not don the gown when she entered the room to clean Resident 83's bedside table.<br><br>Medical record review for Resident 83 was initiated on 8/5/25. Resident 83 was admitted to the facility on [DATE].<br><br>Review of Resident 83's Order Summary report dated 8/5/25, showed a physician's order dated 7/31/25, to implement the EBP related to Resident 83's chronic wound. To apply enhanced barriers 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.<br><br>Review of Resident 83's plan of care showed a care plan problem dated 7/31/25, addressing Resident 83's EBP status. The intervention included to apply the 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.<br><br>3. On 8/6/25 at 0800 hours, during the medication administration observation for Resident 2 with LVN 3, LVN 3 was not observed wearing a gown during the administration of the medications via the GT, the administration of the heparin (anticoagulant medication) injection into Resident 2's abdomen, or the administration of the the nebulizer (a small machine which turns liquid medication into a mist for (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | inhalation delivered by a connected facemask) breathing treatment.<br><br>Medical record review for Resident 2 was initiated on 8/6/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 2's Order Summary Report showed a physician's order dated 6/10/25, to implement the Enhanced Barrier Precaution related to Resident 2's GT use. To apply enhanced barriers 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.<br><br>On 8/6/25 at 0844 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 2 had a GT, which meant LVN 3 should have donned the gown and gloves when administering the mediations to Resident 2, to prevent the cross contamination and transmission of organisms to other residents. LVN 3 verified he did not don the gown during the medication administration observation for Resident 2.<br><br>On 8/11/25 at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings.<br><br>4. Medical record review for Resident 46 was initiated on 8/6/25. Resident 46 was readmitted to the facility on [DATE].<br><br>Review of Resident 46's Order Summary Report showed the following physician's orders:- dated 7/21/25, for daily wound care to the left below the knee area, left below the knee amputation site, right first toe, right third toe, and right fifth toe wound care.<br><br>- order dated 7/28/25, for daily wound care to the right lower leg.<br><br>- dated 7/31/25, for the EBP related to dialysis site and chronic wound. Apply the EBP to prevent the spread of infections for care activities including wound care.<br><br>On 8/7/25 at 0841 hours, a wound care observation for Resident 46 was conducted with LVN 1. CNA 2 was present to assist with the positioning of the resident. Resident 46 was observed lying in bed as LVN 1 completed the wound care to the resident's left below the knee area. LVN 1 then moved on to perform the wound care to the resident's left BKA (below the knee amputation). During the resident's BKA wound care, LVN 1 asked CNA 2 to get her a box of gloves. CNA 2 retrieved a box of gloves and LVN 1 instructed the CNA to place the gloves by the foot of Resident 46's mattress. LVN 1 completed the wound care to Resident 46's BKA site and proceeded to perform wound care on the resident's right lower leg and toes, using the gloves from the cardboard box on the mattress. The open cardboard box of gloves was observed approximately one inch from the resident's right heel. The resident's toes were above the open cardboard box of gloves while the licensed nurse was performing wound care to the resident's toes. After completing the resident's wound care, LVN 1 took the box of gloves from the resident's mattress and placed it on top of another box of gloves on the wall holder. LVN 1 stated the gloves on the wall holder were used on all the three residents in the room. LVN 1 verified she should not have taken the box of gloves from the resident's bed and placed it on the wall for use.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 5. Medical record review for Resident 4 was initiated on 8/6/25. Resident 4 was readmitted to the facility on [DATE].<br><br>Review of Resident 4's Order Summary Report showed the following physician's orders:- dated 6/6/25, to administer the Osmolyte1.2 (type of enteral feed) via GT daily at 1300 hours. - dated 7/31/25, for the EBP related to the resident's GT use.<br><br>On 8/6/25 at 1350 hours, LVN 6 was observed starting Resident 4's GT feeding. LVN 6 was observed donning on an isolation gown, however the LVN did not use the ties to tie the gown at the back of the neck and waist. While LVN 6 was checking the resident's GT and connecting the tube feeding, the isolation gown fell from her shoulders down to her elbows, leaving her upper torso exposed. LVN 6 verified the gown was not tied and fell during the GT care for Resident 4.<br><br>On 8/6/25 at 1404 hours, an interview was conducted with the IP. The IP stated the EBP are in place to reduce the risk of infections and MDROs. The IP stated the isolation gowns should be tied at the neck and waist when worn.<br><br>6. Review of the facility's Enhanced Standard Precaution signage showed everyone must perform hand hygiene before entering the room. Anyone participating in any of these six moments must also don gown and gloves for morning and evening care, toileting and changing incontinence briefs, caring for devices and giving medical treatments, wound care, cleaning and disinfecting the environment, and mobility assistance and preparing to leave room.<br><br>On 8/5/25 at 0907 hours, during the initial tour of the facility, an EBP signage was observed outside of Resident 3's room. There was a small drawer on Resident 3's door which contained gloves, gowns, and a bottle of alcohol-free wipes. CNA 8 was observe assisting Resident 3 in bed, touching the linens, and turning and repositioning the resident without wearing the gown.<br><br>Medical record review for Resident 3 was initiated on 8/5/25. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 3's Order Summary Report for August 2025 showed a physician's order dated 8/1/25, to observe EBP due to the catheter, gastric tube site, and dialysis site. To apply the enhanced barrier 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.<br><br>On 8/5/25 at 1506 hours, an interview for Resident 3 was conducted with CNA 8. CNA 8 was informed of the above observation, while she assisted Resident 3 in bed. CNA 8 denied providing direct contact care to the resident. However, CNA 8 was informed of the observation of her touching the resident's bed linens and holding the resident's hand.<br><br>On 8/5/25 at 1512 hours, an interview for Resident 3 was conducted with the IP. The IP verified and acknowledged the above findings. The IP stated CNA 8 should have donned a gown when providing care to the resident.<br><br>On 8/11/25 at 1139 hours, an interview was conducted with the DON. The DON was informed and verified the findings. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility P&P review, and CDC Immunization Recommendations, the facility failed to offer the COVID-19 vaccinations to three of seven residents (Residents 7, 17, and 18) reviewed for immunizations. * Residents 7, 17, and 18 were eligible to receive the COVID-19 vaccine, in accordance with the facility's P&P and CDC recommendations. However, the facility failed to offer the COVID-19 vaccine to these residents. These failures increased the residents' risk for being inadequately vaccinated against COVID-19 infection and placed the residents at risk for negative health outcomes were they to develop the COVID-19 infection.Findings: Review of the CDC Recommended Adult Immunization Schedule dated 2025 showed the recommended routine COVID-19 vaccinations for individuals aged 65 years and older. The recommendations showed the following: For individuals previously vaccinated before 2024-25 vaccine with: * One or more doses Moderna or Pfizer-BioNTech: Administer one dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least eight weeks after the most recent dose. * One dose Novavax: Administer one dose 2024-25 Novavax three to eight weeks after most recent dose. If more than eight weeks after most recent dose, administer one dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. * Two or more doses Novavax: Administer one dose 2024-25 Moderna or Novavax or Pfizer-BioNTech at least eight weeks after the most recent dose. * One or more doses [NAME]: Administer one dose 2024-25 Moderna or Novavax or Pfizer-BioNTech. Review of the facility's P&P titled COVID-19 Vaccination revised 6/9/23, showed it is the policy of the facility to minimize the risk of acquiring, transmitting, or experiencing complications from COVID-19 by educations and offering our residents the COVID-19 vaccine. Residents should receive the recommended age-appropriate vaccine dosage based on their age on the day of vaccination. COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC and/or FDA guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or refuses to receive the vaccine. The resident's medical record will include documentation of the following: Each dose of the vaccine administered to the resident or if the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal. 1. Medical record review for Resident 7 was initiated on 8/5/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Immunizations Record dated 8/7/24, showed Resident 7 was [AGE] years of age and received a Pfizer COVID-19 vaccine booster on 6/3/22. Further review of Resident 7's Immunizations Record and medical record failed to show documentation Resident 7 was offered or received another dose of the COVID-19 vaccine (after the dose on 6/3/22), in accordance with the CDC vaccination recommendations for residents age [AGE] years and older, and in accordance with the facility's P&P. 2. Medical record review for Resident 17 was initiated on 8/5/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's Immunization Report dated 8/7/24, showed Resident 17 was [AGE] years of age and received a COVID-19 vaccine (unknown manufacturer) on 4/9/21. Further review of Resident 17's Immunization Report and medical record failed to show documentation Resident 17 was offered or received another dose of the COVID-19 vaccine (after the dose on 4/9/21), in accordance with the CDC vaccination recommendations for residents age [AGE] years and older, and in accordance with the facility's P&P. 3. Medical record review for Resident 18 was initiated on 8/5/25. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Immunization Report dated 8/7/25, showed Resident 18 was [AGE] years of age and received a Moderna COVID-19 vaccine booster on 11/12/21. Further review of Resident 18's Immunization Report and medical record failed to show documentation Resident 18 was offered or received another dose of the COVID-19 vaccine (after the dose on 11/12/21), in accordance with the CDC vaccination recommendations for residents age [AGE] years (continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and older, and in accordance with the facility's P&P. On 8/7/25 at 1017 hours, an interview, medical record review, facility P&P review, and concurrent CDC Immunization Recommendations review was conducted with the IP. The IP reviewed Residents 7, 17, and 18's immunization and medical records and verified the residents' medical records failed to show documentation the residents were offered or received the current recommended dose of the COVID-19 vaccine, in accordance with the CDC vaccination recommendations for residents age [AGE] years and older, and in accordance with the facility's P&P. The IP stated he would contact the residents and/or the residents' responsible parties to offer and obtain consents for the recommended COVID-19 vaccines. The IP stated he would then document in the residents' medical record whether they received the recommend COVID-19 vaccine or if they refused the COVID-19 vaccine after a discussion specific to the risk and benefits. |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop, implement, and/or maintain an effective training program for all new and existing staff members.<br><br>**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 failed to implement and maintain an effective training program for the existing facility staff. * The facility failed to ensure only qualified staff managed the resident oxygen delivery equipment. The SSD was observed turning Resident 1's oxygen concentrator off and on, in an attempt to troubleshoot a potential malfunction. * The facility failed to complete the annual skill performance for LVN 3. * The facility failed to ensure the facility staff scheduled for the 11-7 shift were provided with the in-services on 2/21 and 3/22/25. These failures posed the risk for untrained facility staff providing care to residents, which posed the risk for adverse events and negative health outcomes.Findings:<br><br>1. Medical record review for Resident 1 was initiated on 8/5/25. Resident 1 was admitted to the facility on [DATE].<br><br>Review of Resident 1's physician's order dated 5/25/25, showed an order for oxygen to be administered via tracheostomy collar, at a rate of five LPM, may titrate oxygen to maintain oxygen saturation greater or equal to 92%.<br><br>Review of Resident 1's Care Plan Report revised 5/22/25, showed Resident 1 had altered respiratory status and was at risk for difficulty breathing related to tracheostomy, CHF, and chronic respiratory failure. The interventions included the administration of oxygen at a rate of five LPM via tracheostomy.<br><br>On 8/6/25 at 1110 hours, an observation and concurrent interview was conducted with the SSD. The SSD was observed in Resident 1's room turning Resident 1's oxygen concentrator off and on. The SSD was asked what he was doing, to which he replied, the machine was beeping so I turned it off and on. The SSD was asked if he had training specific to managing the oxygen concentrator functionality, to which he replied, no. The SSD was asked if he should turn the oxygen concentrator off and on, to which he replied, no, I should have contacted the nurse.<br><br>On 8/6/25 at 1123 hours, an interview was conducted with the DON. The DON was informed the SSD was observed in Resident 1's room having turned Resident 1's oxygen concentrator off and on. The DON stated the SSD's action was not within the SSD's scope of practice. The DON stated the SSD having turned off the oxygen concentrator could result in negative health outcomes for Resident 1.<br><br>On 8/6/25 at 1328 hours, an interview was conducted with the DSD. The DSD was asked if the SSD's job duties and responsibilities included the operation of or trouble shooting the residents' oxygen delivery equipment (oxygen concentrators), to which the DSD replied, no. The DSD stated the facility did not train the SSD to operate or trouble shoot the residents' oxygen delivery equipment.<br><br>2. Review of the facility's P&P titled Evaluation Process dated 12/19/22, showed it is the policy of our facility to review the work performance of employees with a formal written evaluation annually.<br><br>Review of LVN 3's Licensed Nurse Competency (Annual) dated 3/18/24, failed to show the following competencies were assessed. The assessment method, date and educator initials were left black:<br><br>- Effective communication;- Requirements of the Compliance and Ethics Program;- Safety and<br>(continued on next page) |

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|---|---|---|---|
| | 055622 | A. Building<br>B. Wing | 08/11/2025 |

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| F 0940<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | emergency procedures;- Person-centered care;- Cultural competency (e.g., LGBT, religious affiliation, and other characteristics of the resident population);- Standard and transmission-based precautions/PPE;- Infection reporting;- Behavioral health, including:- Trauma-informed care;- Mood disorders (e.g., depression, anxiety);- Psychiatric disorders (e.g., schizophrenia, personality disorders);- Substance abuse disorders;- Implementation of non-pharmacological interventions;- Suicide precautions;- Documentation;- Pain management;- Use of alarms and restraints; and- Advance directives.<br><br>3. Review of the facility's in-service sign-in sheet titled Problems and Needs of the Aged and Chronically Ill dated 2/21/25, showed the CNA signatures were documented for 7-3 and 3-11 shifts. However, there was no documentation on the sign-in sheet to show the 11-7 shift facility staff were provided with the in-service.<br><br>Review of the facility's in-service sign-in sheet titled Trauma-Informed Care dated 3/22/25, showed the CNA signatures were documented for the 7-3 and 3-11 shifts. However, there was no documentation on the sign-in sheet to show the 11-7 shift facility staff were provided with the in-service.<br><br>On 8/7/25 at 1014 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD was asked about LVN 3's annual skill competency, specifically regarding the competencies with the missing documentation. The DSD stated she checked off what she observed on the day of the assessment. The DSD stated the remaining competencies were covered by other vendors or lecturers. The DSD was then asked to provide the dates when missing competencies were completed for LVN 3. The DSD stated she would need to look for the information, as it was not readily available. When asked how the DSD ensured the skills check list was completed, given there were no dates and/or educator initials documented, the DSD acknowledged she could not verify when LVN 3 completed the competencies not assessed by her. The DSD was also asked whether the in-service trainings listed above were provided to facility staff working the 11-7 shift. The DSD stated she had provided the in-service training for the 11-7 shift facility staff but was unable to provide the documentation. The DSD verified the above findings. |

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| F 0641<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Ensure each resident receives an accurate assessment.<br><br>**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 the MDS assessment was coded accurately for two of 21 final sampled residents (Residents 10 and 69). * Resident 69's MDS assessment was not coded accurately to show he was administered oxygen while at the facility.* Resident 10's MDS assessment showed the resident had one fall, instead of three falls.These failures posed the risk for the residents to not have an individualized plan of care based on the residents' specific needs. Findings: 1. Medical record review for Resident 69 was initiated on 8/5/25. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Progress Notes *NEW* showed the following:- dated 7/13/25 at 0325 hours, showed oxygen was administered at 2 lpm via nasal cannula. - N Adv Skilled Evaluation dated 7/14/25 at 1638 hours and 7/15/25 at 1620 hours, showed the resident received oxygen via nasal cannula.Review of Resident 69's admission MDS assessment dated [DATE], showed was not coded to reflect the resident received the oxygen (while a resident). The MDS instructions defined while a resident meaning, while a resident was at the facility and within the last 14 days. On 8/8/25 at 1024 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator stated when completing an MDS for the resident's oxygen administration, the MDS was coded for any oxygen administered during the look-back period (14 days while a resident). The MDS Coordinator reviewed Resident 69's medical record and stated the resident received an oxygen during the look back period for the MDS assessment dated [DATE], and verified the MDS was coded incorrectly. 2. Medical record review for Resident 10 was initiated on 8/5/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's eINTERACT Change in Condition Evaluation - V 5.1 assessments showed the resident had falls on 3/22, 4/1, and 4/3/25 (total of three falls). Review of Resident 10's Discharge MDS assessment dated [DATE], showed the resident had one fall since the resident's previous MDS assessment. Further review of Resident 10's MDS assessments showed the previous MDS assessment was completed on 3/6/25. On 8/8/25 at 1144 hours, an interview and concurrent medical record review was conducted with the MDS Coordinator. The MDS Coordinator reviewed Resident 10's medical record and stated the resident had three falls during the look-back period prior to the completion of the MDS assessment dated [DATE]. The MDS Coordinator verified the MDS assessment was coded incorrectly for Resident 10. |

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| F 0657<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**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 revise the care plans for two of 21 final sampled residents (Residents 10 and 69). * The facility failed to timely resolve Resident 10's care plan for the IV therapy. * The facility failed to timely resolve Resident 69's care plan for the quetiapine (antipsychotic) medication. These failures posed the risk of not providing the residents with individualized and person-centered care. Findings: 1. Medical record review for Resident 10 was initiated on 8/5/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's Care Plan Report showed a care plan focus initiated on 6/12/25, addressing the resident's IV therapy and IV antibiotics for UTI. Review of Resident 10's Order Summary Report failed to show the physician's orders for an IV therapy or IV antibiotics. On 8/7/25 at 1442 hours, an interview and concurrent medical record review was conducted wit the DON. The DON stated Resident 10's IV therapy and antibiotics for UTI were completed in June 2025 and the resident's care plan should have been revised and resolved when the IV therapy and antibiotics were completed. 2. Medical record review for Resident 69 was initiated on 8/5/25. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Care Plan Report showed care plan focus initiated on 7/22/25, addressing the resident's quetiapine medication. Review of Resident 69's Order Summary Report failed to show the physician's orders for the quetiapine medication. On 8/7/25 at 1437 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 69's quetiapine medication was discontinued on 8/1/25, and the care plan should have been revised and resolved when the medication was discontinued. |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**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 residents' medical records were accurate for one of three residents (Resident 79) reviewed for closed medical record, one of 21 final sampled residents (Resident 59), and one nonsampled resident (Resident 32).* The facility documented Resident 79's temperature and pain level were obtained on [DATE], however, Resident 79 expired on [DATE].* The facility failed to ensure the accurate documentation for the administration of the Norco (narcotic) pain medication for Residents 32 and 59. These failures resulted in the residents' medical records containing inaccurate information.Findings:<br><br>Review of the facility's P&P titled Documentation in Medical Record revised [DATE], showed documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.<br><br>1. Closed medical record review for Resident 79 was initiated on [DATE]. Resident 79 was admitted to the facility on [DATE], and expired on [DATE].<br><br>Review of Resident 79's Nurses Progress Note dated [DATE] at 1019 hours, showed on [DATE] at 0730 hours, the licensed nurse was notified by the care staff that Resident 79 was not breathing. Resident 79 had absent breath sounds and a carotid pulse. Resident 79's time of death was on [DATE] at 0738 hours.<br><br>Review of Resident 79's Temperature Summary dated [DATE] at 1243 hours, showed documentation Resident 79's temperature was obtained and was measured at 97.1 degrees Fahrenheit.<br><br>Review of Resident 79's Pain Level Summary dated [DATE] at 1243 hours, showed documentation Resident 79's pain level was obtained and Resident 79 had complained of pain at a level of 6 out of 10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst).<br><br>On [DATE] at 0942 hours, an interview and concurrent closed medical record review was conducted with the DON. The DON verified Resident 79 expired on [DATE]. The DON then verified the documentation contained in Resident 79's medical record, which showed Resident 79's temperature and pain level were obtained on [DATE], was inaccurate as Resident 79 was not alive on [DATE].<br><br>2. Medical record review for Resident 59 was initiated on [DATE]. Resident 59 was admitted to the facility on [DATE].<br><br>Review of Resident 59's Order Summary Report showed the following physician's orders dated [DATE]:<br><br>- to administer oxycodone (narcotic pain medication) 5 mg one tablet by mouth every four hours as needed for moderate pain (pain level of 4 to 6 out of 10); and<br><br>- to administer oxycodone 10 mg one tablet every four hours as needed for severe back pain (pain level of 8 to 10 out of 10).<br><br>Review of Resident 59's Antibiotic or Controlled Drug Record for the oxycodone medication 10 mg one<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | tablet showed the licensed nurse documented the removal of the medication on [DATE] at 1105 hours.<br><br>Review of Resident 59's MAR for [DATE] showed the licensed nurse documented the oxycodone 5 mg was administered to Resident 59 on [DATE], instead of the oxycodone 10 mg.<br><br>3. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE], and readmitted on [DATE].<br><br>Review of Resident 32's Order Summary Report showed the following physician's orders dated [DATE]:<br><br>- to administer hydrocodone-acetaminophen (narcotic pain medication) 5-325 mg 0.5 (half) tablet by mouth every six hours as needed for moderate pain (pain level from 4 to 6 out of 10); and<br><br>- to administer hydrocodone-acetaminophen 5-325 mg one tablet by mouth every six hours as needed for severe pain (pain level from 6 to 10 out of 10).<br><br>Review of Resident 32's Antibiotic or Controlled Drug Record for the hydrocodone-acetaminophen 5-325 mg tablet (whole tablet) showed the licensed nurse documented the removal of the medication on [DATE] at 0145 hours.<br><br>Review of Resident 32's MAR for [DATE] showed the licensed nurse documented the hydrocodone-acetaminophen 5-325 mg half tablet was administered to Resident 32, instead of the hydrocodone-acetaminophen 5-325 mg one tablet on [DATE] at 0146 hours.<br><br>On [DATE] at 0841 hours, an interview and concurrent medical record review for Residents 32 and 59 was conducted with the DON. The DON stated he spoke to the licensed nurses who documented the administrations of the PRN pain medications for the above dates and times for Residents 32 and 59 and the licensed nurses stated they administered the dose of the medication that was removed from the controlled drug record. However, the licensed nurses had incorrectly documented the administration of the medications in the residents' MAR. The DON stated he expected the documentation by the licensed nurses in the residents' medical record to be accurate to reflect the care the residents were receiving.<br><br>On [DATE] at 1124 hours, an interview was conducted with the Administrator, DON, and Nurse Consultant. The Administrator, DON, and Nurse Consultant were informed and acknowledged the above findings. |

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| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>Based on interview and facility document review, the facility failed to ensure 16 resident rooms measured at least a minimum of 80 square feet per resident. This failure had the potential to not be compliance with the requirement. Findings: Review of the facility's Client (Resident) Accommodations Analysis form (undated) showed Rooms 1, 3, 5, 6, 7, 9, 11, 12, 14, 15, 17, 18, 19, 20, 21, and 23 measured less than a minimum of 80 square feet per resident. On 8/6/25 at 1320 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator verified there were 16 resident rooms not meeting the minimum required 80 square feet per resident. |