STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055873	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care Center	8665 LA Mesa Blvd. LA Mesa, CA 91942

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure safe and effective pharmaceutical services when:Random controlled medication (medications with a high abuse potential) use audit for three of four sampled residents (Residents 73, 4, and 50) indicated medications were signed out of the controlled drug record (CDR, count sheet used to track controlled medications), but were not documented on the Medication Administration Record (MAR, section of the medical record where all medications given to the resident are recorded to ensure patient safety) to indicate they were administered to the residents. In addition, for Resident 50, an administration was documented on the MAR, but not signed out on the CDR. These failures had the potential for diversion (unlawful distribution or use), inadequate narcotic accountability, and the potential to not meet the needs of the residents in the facility.Medications were not administered as prescribed for one of four residents sampled for controlled medication audits (Resident 50) and for one of five residents sampled for unnecessary medications (Resident 8). These failures had the potential for Residents 50 and 8 to potentially experience negative health outcomes.Ozempic (an injectable medication for diabetes, a condition characterized by impaired blood sugar control) was not available for administration for Resident 8 two times in an eight-week period. This failure had the potential for Resident 8 to not get the full therapeutic effect of his medication.Insulin (a medication used lower blood sugar) pens (devices used to deliver an injectable drug into the body) in one of four inspected Medication Carts were observed without an open date recorded for Residents 4, 31, and 8. This failure had the potential to negatively alter the drug's stability, physical properties and effectiveness, which could result in adverse resident outcomes.Findings:1. During an inspection of Station 1 Medication Cart 2 conducted with Licensed Nurse (LN) 33 on 4/27/26 at 9:11 A.M., the CDRs for two random residents receiving PRN (as needed) controlled medications were requested for review. An additional CDR was requested from Station 2 Medication Cart 1 for review on 4/28/26 at 11:10 A.M. from LN 34. Another CDR was requested from Station 2 Medication Cart 2 on 4/28/26 at 3:13 P.M. from LN 35.A review of Resident 73's medical record indicated an order for hydrocodone-acetaminophen (a controlled medication used to manage pain) 7.5/325 milligram (mg, unit of measurement) tablet - one tablet by mouth every 6 hours as needed for moderate to severe pain (7-10 level pain out of 10, 0 being no pain and 10 being the worst pain imaginable), dated 4/15/25.During a concurrent interview and record review with the Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 4/30/26 at 11:41 A.M., a review of Resident 73's CDR for hydrocodone-acetaminophen 7.5/325 mg and April 2026 MAR indicated the nursing staff signed out of the CDR, but did not document the medication administration on one occasion: 4/18/26 at 4 A.M.The DON confirmed there was no documentation on the MAR on 4/18/26 at 4 A.M. A review of Resident 4's medical record indicated orders for oxycodone-acetaminophen (a controlled medication used to manage pain) 5/325 mg tablet - give one tablet by mouth every 6 hours as needed for moderate to severe pain (4-10 level pain), started 4/15/26.During a concurrent interview and record review with the DON and ADON on 4/30/26 at 11:41 A.M., a review of Resident 4's CDR for oxycodone-acetaminophen 5/325 mg and April 2026 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet of oxycodone-acetaminophen (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/325 mg, but did not document the medication administration on one occasion: 4/24/26 at 3:50 A.M.The DON confirmed the lack of documentation in the medical record for 4/24/26 at 3:50 A.M. A review of Resident 50's medical record indicated orders for morphine sulfate (a controlled medication used to manage pain), including the following:morphine sulfate oral solution (in liquid form) 100 mg per 5 mL (milliliters, unit of measurement for volume) - give 0.25 mL by mouth every 4 hours as needed for severe pain (7-10 level pain), started 11/3/25 and discontinued 11/8/25, andmorphine sulfate oral solution 100 mg per 5 mL - give 0.25 mL by mouth every 4 hours as needed for moderate to severe pain (4-10 level pain), started 11/9/25 and discontinued 12/5/25.During a concurrent interview and record review with the DON and ADON on 4/30/26 at 11:41 A.M., a review of Resident 50's medical record was conducted. Resident 50's CDR indicated nursing staff signed out of the CDR, but did not document the medication administration on the following dates:11/4/25 at 1 A.M.11/6/25 at 1:30 A.M.11/6/25 at 5:30 A.M.11/11/25 at 1 A.M.11/11/25 at 5:30 A.M.11/12/25 at 12:30 A.M.11/12/25 at 5:30 A.M.11/13/25 at 12 A.M.11/13/25 at 4 A.M.The DON confirmed she could not find any documentation of administration on Resident 50's November 2025 MAR for the above dates and times.Additionally, there was an administration documented on the MAR for 11/7/25 at 3:05 P.M., but not signed out on the CDR. The DON acknowledged the CDR was not signed out on 11/7/25 at 3:05 P.M.The DON stated documentation should be accurately charted on the CDR and MAR. The DON stated the documentation on the CDR and MAR should match. A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 4/19, indicated, .The nurse administering the medication is responsible for recording.time of administration.quantity of the medication remaining.signature of nurse administering medication. 2a. A review of Resident 50's medical record indicated orders for morphine sulfate, including the following:morphine sulfate oral solution 100 mg per 5 mL - give 0.25 mL by mouth every 4 hours as needed for severe pain (7-10 level pain), started 11/3/25 and discontinued 11/8/25,morphine sulfate oral solution 100 mg per 5 mL - give 0.25 mL by mouth every 4 hours as needed for moderate to severe pain (4-10 level pain), started 11/9/25 and discontinued 12/5/25,morphine sulfate oral solution 100 mg per 5 mL - give 0.25 mL by mouth every 4 hours as needed for severe pain (7-10 level pain), started 1/30/26, andmorphine sulfate oral tablet extended release (ER, signed to release slowly) - give one tablet by mouth every 12 hours for pain management, started 11/11/25 and discontinued on 2/4/26.During a concurrent interview and record review on 4/30/26 at 11:41 A.M. with the DON and ADON, Resident 50's medical record was reviewed.Resident 50's CDR was signed out on 12/26/25 without a time. There was no MAR documentation for morphine sulfate oral solution on 12/26/25. Resident 50's medical record indicated there was no active morphine sulfate oral solution order on 12/26/25.The DON stated morphine sulfate oral solution should not have been given on 12/26/25 because that order was not active at that time. Resident 50 received a dose of morphine sulfate oral solution, as documented on his February 2026 MAR, despite having a pain level less than 7 on 2/2/26 at 8:10 A.M. when his pain level was 6.The DON acknowledged this documented administration on Resident 50's February 2026 MAR. The DON stated the morphine sulfate oral solution was ordered for pain levels greater than or equal to 7. 2b. A review of Resident 8's medical record indicated orders for the following medication:metoprolol tartrate (a medication used to treat hypertension, high blood pressure) 25 mg tablet - give half a tablet one time a day for hypertension. Hold if SBP (systolic blood pressure, the top number in a blood pressure reading) less than 110 or apical pulse (heart rate) less than 60, started 2/21/24.During a concurrent interview and record review on 4/29/26 at 3:11 P.M. with the DON, Resident 8's medical record was reviewed. Documentation on Resident 8's April 2026 MAR indicated Resident 8 received doses of metoprolol tartrate despite having a SBP less than 110 on the following dates:4/2/26 blood pressure (BP) 103/744/10/26 BP 98/62The DON acknowledged the above entries in Resident 8's April 2026 MAR. The DON stated the medication should have been held (not administered) on 4/2/26 and 4/10/26 because Resident 8's BP was outside the hold parameter. A review of the facility's P&P titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accordance with prescriber orders. 3. A review of Resident 8's medical record indicated orders for the following medication:Ozempic (a medication used to treat diabetes) - inject 2 mg subcutaneously (into the fat under the skin) in the evening every Friday for DM (diabetes mellitus) management, started 2/6/26 and discontinued 3/29/26, reinitiated 4/3/26.Resident 8's medical record indicated Ozempic was not given, as documented on his March 2026 and April 2026 MARs, on the following dates:3/13/26 code 134/3/26 code 13The MAR indicated code 13 = Drug Not Available.The DON confirmed the meaning of the code 13 and acknowledged the MAR entries on the above dates for Ozempic. The DON stated nursing staff were expected to follow up with pharmacy if medications were unavailable for administration and inform their charge nurse or the DON of the unavailability.A review of the facility's P&P titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY, effective 1/15/25, indicated, Medications.are received from the dispensing pharmacy on a timely basis. The facility maintains accurate records of medication order and receipt. 4. During a concurrent observation and interview on 4/27/26 at 9:11 A.M., an inspection of Station 1 Medication Cart 2 was conducted with LN 33. Four insulin pens were observed with blank date open stickers affixed to them.insulin glargine-yfgn (a type of long-acting insulin) pen for Resident 4insulin glargine-yfgn (a type of long-acting insulin) pen for Resident 31Lantus Solostar (a type of long-acting insulin) 100 units/mL pen for Resident 8insulin lispro (a type of rapid-acting insulin) 100 units/mL pen for Resident 8LN 33 confirmed that the date open stickers affixed to the pens were blank. LN 33 stated all four insulins had been opened and were being used.Each one of the insulin pens had a note on the prescription label that read, Refrigerate unopened.pens. Once in use, do not refrigerate. Store.pen in use at room temperature. DISCARD UNUSED PORTION AFTER 28 DAYS.During an interview with the DON on 4/29/26 at 3:11 P.M., the DON stated nursing staff were to label any medications removed from the refrigerator. The DON stated if those medications were in the medication carts, they needed to be labeled with the date it was opened.A review of a leaflet provided by the facility, titled Instructions for Use, for insulin glargine-yfgn, revised 3/25, indicated, .Keep new pens in the refrigerator.After first use: Keep.pen at room temperature.Only use.pen for up to 28 days after its first use. Throw away the Insulin Glargine-yfgn pen you are using after 28 days, even if it still has insulin left in it.A review of the Lantus package insert (PI, document from the drug manufacturer on how to safely and effectively use medications) and Instructions for Use for Lantus Solostar, provided by the facility, revised 5/25, indicated, .Keep new pens in the refrigerator.After first use [k]eep.pen at room temperature.Only use.pen for up to 28 days after its first use. Throw away the LANTUS Solostar pen you are using after 28 days, even if it still has insulin left in it.A review of the facility's P&P titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in accordance with prescriber orders, including any required time frame.12. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure one of one sampled resident (17) reviewed for dignity had sufficient personal clothing of choice and footwear.This failure resulted in Resident 17 remaining in a hospital gown instead of personal clothing and without available footwear, with the potential to diminish the resident's sense of self-worth.Resident 17 was admitted to the facility on [DATE] with a diagnosis of cachexia (severe weight loss and muscle wasting caused by serious illness) per the facility admission record.During an observation and interview on 4/29/26 at 9:50 A.M., Resident 17 sat in bed wearing a hospital gown. Resident 17 stated she was in her hospital gown because she did not have enough personal clothing and wanted to purchase clothing of her choice. Resident 17 stated she had requested access to her personal funds to buy clothing, but the facility had not provided the money after she made the request. Resident 17's closet contained one jacket, one dress, and some folded pants at the bottom of the closet. The closet did not contain shoes. One slipper was present in the closet, but the matching pair was unable to be located.During an observation and interview in Resident 17's room on 4/29/26 at 10:12 A.M., Licensed Nurse (LN) 1 stated she was aware Resident 17 had requested additional clothing and had provided Resident 17 clothing from the facility's donated clothing supply. LN 1 stated she was unaware Resident 17 had personal funds and wanted to buy clothing. During an observation of the clothing in Resident 17's closet, LN 1 acknowledged Resident 17's limited personal clothing, one slipper without the matching slipper, and no other footwear. LN 1 stated Resident 17 not having sufficient footwear or being able to purchase and choose personal clothing was a dignity concern. During an interview on 4/30/26 at 3:24 P.M., the director of nursing (DON) stated the facility was expected to provide for residents' basic needs, such as clothing and food. DON stated if Resident 17's request to buy clothing and have access to basic footwear was not met, it could impact the resident's emotional well-being and dignity. A review of the facility policy titled, Dignity, revised 2/2021, indicated, Policy Statement: Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Policy Interpretation and Implementation:. 2. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values and beliefs. This begins with the initial admission and continues throughout the resident's facility stay. 3. Individual needs and preferences of the resident are identified through the assessment process. 5. When assisting with care, residents are supported in exercising their rights. For example, residents are:. c. encouraged to dress in clothing that they prefer.A review of the facility policy titled, Resident Rights Guidelines for All Nursing Procedures, revised 10/2010, indicated, Purpose: To provide general guidelines for resident rights while caring for the resident. Preparation:m1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including: b. Resident dignity and respect;. Resident freedom of choice.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (17) had access to personal funds when the resident requested money to purchase clothing of choice. As a result, Resident 17 was unable to purchase desired clothing and continued to wear a hospital gown.Resident 17 was admitted to the facility on [DATE] with a diagnosis of cachexia (severe weight loss and muscle wasting caused by serious illness) per the facility admission record.During an observation and interview on 4/29/26 at 9:50 A.M., Resident 17 sat in bed wearing a hospital gown. Resident 17 stated she wore the hospital gown because she did not have enough personal clothing. Resident 17 stated she wanted to buy clothing of her choosing and had requested access to her money, but the facility had not provided access to her money. Resident 17 stated she was supposed to receive around $1000 from social security on a monthly basis.During a concurrent observation and interview with Resident 17 and licensed nurse (LN) 1 on 4/29/26 at 10:12 A.M., Licensed Nurse (LN) 1 stated Resident 17 had requested additional clothing. LN 1 stated she was not aware Resident 17 had personal funds available. LN 1 stated social services handled the management of all resident funds. During an interview and record review on 4/29/26 at 10:33 A.M., the social service director (SSD) confirmed Resident 17 previously resided at a board and care facility (BCF) before admission to the facility on 5/8/25. The SSD reviewed two social services progress notes (SSPN). A SSPN dated 7/9/25 indicated the SSD conferred with the BCF regarding Resident 17's and determined the resident required a higher level of care than the BCF could provide. The SSPN further indicated Resident 17 would be unable to return to the BCF. The 7/9/25 SSPN did not indicate the SSD discussed Resident 17's social security income, personal funds, or access to funds with the BCF. The SSD stated she did not speak with the BCF again until 4/24/26 and did not know Resident 17 received social security income until 4/24/26.A review of a SSPN, dated 4/24/26, indicated Resident 17 received social security income which the BCF had continued the resident's money to pay $1,440 in monthly rent. A review of SSPN's following the 7/9/24 note up to the 4/24/26 indicated facility did not document any attempts to contact the BCF regarding Resident 17's social security income or personal funds. During an interview and record review on 4/29/26 at 10:48 A.M., the business office manager (BOM) stated the facility used the MC 171 admission and discharge notification form to identify resident income and benefits, including social security income. Review of Resident 17's MC 171 signed, 5/11/25, indicated Resident 17's current income was marked as none. The BOM stated the business office was not notified after the facility determined Resident 17 would not return to the BCF on 7/9/25, and the business office did not submit and updated MC 171 to reflect Resident 17's current income or reassess Resident 17's social security benefit status. The BOM stated Resident 17 declined to sign the form the financial institution needed to open a resident trust account. The BOM was unable to provide documentation that Resident 17 declined to sign the form. During a review of Resident 17's admission packet, the BOM acknowledged Resident 17 had signed the document titled, Resident Trust Fund Authorization (RTFA), on 5/11/26 along with a facility representative giving the facility permission to manage the residents money. The BOM stated the form for opening the trust with the financial institution was separate from the RTFA form. The BOM stated she did not notify the SSD that Resident 17 declined to sign the form the bank needed to open a resident trust account.During a follow-up interview on 4/30/26 at 2:42 P.M., the SSD stated the facility had no documentation that social services or the business office contacted the BCF regarding Resident 17's income after Resident 17 became a long-term care resident at the facility. The SSD stated she did not know Resident 17 had declined to sign the form the bank needed to open a resident trust account. The SSD stated because Resident 17 did not have access to her personal funds the resident could not purchase items of her choosing.During an interview on 4/30/26 at 3:24 P.M., the director of nursing (DON) stated she was not made aware of Resident 17's financial request until 4/29/26. The DON (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated if Resident 17 received income it was the facility's responsibility to help ensure all residents had access their personal money. A review of the facility document titled, RESIDENT TRUST FUND AUTHORIZATION, signed by Resident 17 on 5/11/25, indicated, .The resident has the right to manage his/her own financial affairs while in a nursing facility. the resident may wish to deposit personal funds with the facility. The facility will accept those funds and manage them according to the requirements of federal and state law. This allows the resident to have access to his/her personal funds when requested. the facility will comply with the following. The facility will provide the resident convenient access to his/her funds within a reasonable time frame. Resident or resident's representative authorizes the facility to deposit any Social Security checks. into the resident trust account.Resident or resident's representative authorizes the facility to disburse funds to pay for any resident authorized charges.A review of the facility policy titled, Resident Rights Guidelines for All Nursing Procedures, revised 10/2010, indicated, Purpose: To provide general guidelines for resident rights while caring for the resident. Preparation: 1. Prior to having direct-care responsibilities for residents, staff must have appropriate in-service training on resident rights, including . d. Protection of resident funds and personal property;. h. Resident freedom of choice.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility did not ensure professional standards were followed when a resident's change in condition was not followed up on for one of three residents (Resident 10) observed for changes in condition. This failure had the potential for harm due to no follow up of a noted change.Resident 10 was originally admitted to the facility on [DATE], with diagnosis that included: acute (sudden, new) and chronic (over six months) respiratory failure (the lungs cannot deliver enough oxygen to the body and remove carbon dioxide, causing organ damage), muscle spasm; contracture of right and left knees (Contractures are the permanent, abnormal tightening of skin, muscles, tendons, or ligaments, causing joint stiffness and limited movement range {ROM}, according to Resident 10's admission record.On 4/29/26 at 9 A.M., a simultaneous interview and record review was held with the Director of Rehab. (DRH). A Restorative Nurse's Aide (RNA- a health care worker with training in physical therapy) weekly summary dated 4/11/26 was reviewed. The note reflected Resident 10 had increased resistance, and the LN (licensed nurse) was notified. Prior weekly summary notes were reviewed, back to November of 2024. The DPT stated the RNA weekly summaries were non-specific, and used the same language. The DPT stated it could be an issue of copied notes, or the RNA just used the same sentence structures. Either way the notes were non-specific for Resident 10, and had not listed joint motion limits.The DPT also stated the RNA program was overseen by the nursing staff, and meetings were held twice monthly with the lead RNA, the Director of Nursing (DON), the Assistant Director of Nursing (ADON) and the Director of Staff Development (DSD), and the residents on the RNA programs were discussed. The physician's order, dated 4/22/26, was also reviewed. The DPT stated the order was entered incorrectly for one time only for three months and should have been entered correctly three times weekly for three months. The DPT stated she would alert staff to correct the order. On 4/29/26, at 1:45 P.M.,an interview and record review was held with the DON and the ADON. The RNA notes for Resident 10 were reviewed, including the RNA note dated 4/11/26, which reflected the LN was notified for non-specific tightening to unspecified joints for Resident 10. The DON and ADON stated there are twice monthly meetings for the RNA program residents. The DON and ADON also stated they had no memory of Resident 10's name coming up in those meetings, but there was a documented list of residents discusssed. The DON and ADON were unable to locate a record that noted LN was notified or followed up to a report of joint tightening. The weekly RNA summary was signed by an LN. The DON stated it was expected the LN would perform further follow up; and depending on the issue reported, the follow up could be for another evaluation, change in the RNA program or another change that needed to be done. On 4/29/26 at 2:10 P.M., Resident 10's RNA care plan, the most recent RNA weekly assessments for the past four weeks, and a copy of the listing of the residents discussed in the RNA meetings in April 2026 was requested. The RNA unavailable for interview. The documents were not received by the exit. The facility policy: Restorative Nursing Services, dated July 2017, reflectedResidents will receive restorative nursing care as needed to help promote optimal safety and independence.3. Resident goals and objectives are individualized and resdient centered, and are outlined in the resident's plan of care.5. Restorative goals may include, but are not limited to supporting and assisting the resident in: a. adjusting or adapting to changing abilities; b.maintaining or strengthening his/her physiological (related to the physical abilities of the organism) .resources.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to record and document fluid intake for one resident (118) on intravenous (IV - a medical method of delivering fluids, medication, or blood directly into a vein using a small tube and needle) therapy.This failure had the potential for fluid mismanagement that can lead to fluid overload (when the body retains too much water, causing it to build up in blood vessels and tissues) or dehydration (when the body loses more fluids than it takes in, causing it to lack enough water to function normally) to Resident 118.Per the facility's admission sheet, Resident 118 was admitted to the facility on [DATE] with diagnoses that included dysphagia (trouble swallowing). On 4/27/26 at 8:10 A.M., an observation was conducted of Resident 118 in his room. Resident 118 had a peripheral intravenous (PIV - a small, flexible plastic tube inserted into a minor vein to deliver fluids, medication, or blood directly into the bloodstream) line on the back of his right hand and was receiving Dextrose-Sodium Chloride Intravenous Solution 5-0.9 % (IV fluids).On 4/27/26 at 2:30 P.M., a record review was conducted of Resident 118's clinical record. Per the physician's order on 4/16/26, staff was to .Monitor Intake and Output (I&O - a medical check that tracks all fluids going into a patient's body versus everything coming out) every shift x 30days. Further review of the physician's orders indicated that Resident 118 was started on Dextrose-Sodium Chloride Intravenous Solution 5-0.9 % - Use 100 ml/hr intravenously every shift for Hydration x3 days for 3 Days.On 4/28/26 at 9:31 A.M., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that nursing does not record or document IV fluid intake.On 4/29/26 at 2:30 P.M., a concurrent interview and record review was conducted with the Director of Nursing. Resident 118's clinical record indicated that the IV fluids started on 4/21/26 were not being recorded and documented by nursing staff every shift. The DON stated fluid intake includes IV fluids and that it was her expectation nurses record and document the IV fluids every shift.Per the facility policy titled Intravenous Administration of Fluids and Electrolytes, dated March 2022, indicated document.in the resident's medical record and on the intake/output record.Per the facility policy titled Intake, Measuring and Recording, dated October 2010, indicated .fluids taken intravenously are recorded by the licensed nurse.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not monitor for and treat signs of pain for one of one clients (23) reviewed. This failure caused Client 23 to experience avoidable discomfort.Findings: Resident 23 was admitted to the facility on [DATE], with diagnosis that included: anoxic brain damage (a condition where the brain was cut off from oxygen, leading to brain cell death) and acute (sudden) and chronic (long term, over six months) respiratory failure (a condition where the lungs cannot supply enough oxygen to organs). Resident 23 had a tracheostomy (a surgically created hole in the neck to allow air into the windpipe) and was totally fed via gastrostomy (g-tube: a surgically created hole in the stomach with a tube inserted to accept formula nutrition). Resident 23 was unable to speak, and dependent on staff for all Activities of Daily Living (ADL's - dressing, oral care, hygiene, etc.), according to her admission Record and her Plan of Care. On 4/28/26 at 11:05 A.M., Resident 23's records were reviewed. Resident 23's hospital discharge orders for medications, dated 3/30/26, included routine acetaminophen (tylenol), 325 milligram (mg-a unit of measure) tablet, two tablets via g-tube three times a day; and an as needed order for acetaminophen, 650 mg every 6 hours, as needed for pain or fever, not to exceed 4 grams/day (4,000 mg). This medication order list was compared to Resident 23's current medication list, which did not include routine acetaminophen for pain. An order for oxycodone, (a strong narcotic pain reliever) 5mg tablet, give 2.5 mg (1/2 tablet) every 4 hours as needed for severe pain, dated 3/21/26, was located. The record of pain medication administered by staff for Resident 23 in April 2026 was also reviewed. The record reflected oxycodone was given four times in April, with the nurse recording a pain level of 7 or 8 each time. Acetaminophen was not given to Resident 23 during April, according to the record. On 4/29/26, at 10:10 A.M. an observation and interview was conducted of Resident 23's wound care, with attention to Resident 23's facial expressions and response to care. Care was provided by two LN's, 11 and 12. Near the end of care Resident 23 frowned and grimaced, and did not respond to verbal re-assurance that care was almost completed. LN 11 and 12 observed Resident 23's face and LN 11 stated the frown and grimace appeared to be signs of pain. On 4/29/26 at 1:40 P.M., a simultaneous interview and record review was conducted with the Director of Nursing (DON) the Assistant Director of Nursing (ADON). The prior order from the hospital discharge, for acetaminophen three times a day, was read, and no physician's order for acetaminophen was located in the record.The DON was unable to state why the routine acetaminophen was not carried over to the admission orders of 3/30/26 at the facility. The DON stated a referral will be made to the pain specialist to see Resident 23 for pain and spasticity control. Resident 23's Nursing Care Plan for Pain reflected [Resident 23] has acute (new) and chronic (greater than six months) pain related to wounds and immobility. The interventions included: to watch for signs of pain such as .restlessness,. facial grimace,. crying, .breathing changes.Pain relief measures included .reposition .music. dim lights. reassurance. before pain medication was given.give pain medication as ordered.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 11.54% when three medication errors occurred out of 26 opportunities during the medication administration for three of five randomly observed residents (Residents 53, 85, and 106). These failures had the potential for the residents not to get the full therapeutic benefit of their medications or to experience negative health outcomes, such as harm from exposure to medication errors.Findings:During a medication administration observation on 4/27/26 at 7:51 A.M., Licensed Nurse (LN) 30 was observed preparing and administering six medications for Resident 53. The medications included the following tablet: calcium carbonate (a supplement for low calcium) 500 milligram (mg, unit of measurement) chewable tablet.A review of Resident 53's medical record indicated she had an active order for calcium carbonate oral tablet - give 500 mg by mouth four times a day for supplement, dated 10/28/23.A drug review of calcium carbonate from Micromedex (a nationally renowned drug information resource) indicated calcium carbonate 500 mg oral tablets were available as chewable and non-chewable forms.During a concurrent interview and record review of Resident 53's medical record with LN 30 on 4/27/26 at 3:48 P.M., LN 30 stated she did not see the word, chewable on the order.During an interview with the Director of Nursing (DON) on 4/29/26 at 1:41 P.M., the DON stated nursing staff were expected to clarify orders with the prescriber or pharmacy before medication administration if the dosage form on the medication on hand did not match the order. 2. During a medication administration observation on 4/27/26 at 8:45 A.M., LN 31 was observed preparing and administering five medications to Resident 85. LN 31 was observed crushing all of Resident 85's tablets together and mixing the medications with applesauce.Resident 85's medications included the following:levetiracetam (a medication for seizures) 500 mg tablet two times a day for seizure, started 7/16/24.During a concurrent interview and record review of the facility's drug handbook with LN 31on 4/28/26 at 10:56 A.M., the facility's drug handbook indicated levetiracetam tablets should be swallowed whole and shouldn't be chewed, broken, or crushed. LN 31 confirmed he crushed Resident 85's tablets. LN 31 stated based on drug literature levetiracetam should not be crushed.During an interview with the DON on 4/29/26 at 1:41 P.M., the DON stated nursing staff were expected to know which medications should not be crushed. The DON stated nursing staff should clarify orders prior to medication administration. 3. During a medication administration observation on 4/27/26 at 11:43 A.M., LN 32 was observed preparing and administrating nine medications for Resident 106. One of the medications was duloxetine (a medication for depression, a condition characterized by persistent sadness) DR (delayed release, designed to release slowly in the small intestine) 30 mg capsule (medication enclosed in a shell). A review of Resident 106's medical record indicated an active order for duloxetine oral capsule delayed release sprinkle 30 mg - give one capsule by mouth one time a day for depression, started 2/5/26. During a concurrent interview and record review of Resident 106's medical record with LN 32 on 4/27/26 at 3:51 P.M., LN 32 stated the medical record indicated, sprinkle, but she did not see that on the medication administered. During an interview with the Director of Nursing (DON) on 4/29/26 at 1:41 P.M., the DON stated nursing stated were expected to clarify orders with the prescriber or pharmacy before medication administration if the dosage form on the medication on hand did not match the order. A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in accordance with prescribed orders.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of significant medication errors when one of five residents sampled for unnecessary medications (Resident 93) and two of four sampled residents for controlled medication use audits (Residents 73 and 4) received pain medications that were not in accordance with the prescribers' orders. This failure had the potential for diversion (unlawful distribution or use), as well as the potential for Residents 93, 73 and 4 to experience physical dependence (unpleasant symptoms if a medication is suddenly stopped) and adverse effects, such as sedation (sleepiness), dizziness and respiratory depression (slowed or shallow breathing).Findings:A review of Resident 93's medical record indicated an order for oxycodone-acetaminophen (a controlled medication used to manage pain) 7.5/325 mg (milligram, unit of measure) tablet - give one tablet by mouth every 4 hours as needed for severe pain (7-10 level pain, 0 being no pain, 10 being the worst pain imaginable), started 3/11/26.During a concurrent interview and record review on 4/29/26 at 3:11 P.M. with the Director of Nursing (DON), Resident 93's medical record was reviewed. Resident 93 received doses, as documented on his April 2026 Medication Administration Record (MAR, section of the medical record where all medications given to the resident are recorded to ensure patient safety), despite a pain level less than 7 on the following dates:4/5/26 at 5:01 P.M. pain level 54/5/26 at 9:02 P.M. pain level 54/8/26 at 10:59 A.M. pain level 44/11/26 at 10:21 A.M. pain level 54/11/26 at 2:21 P.M. pain level 14/12/26 at 9:15 A.M. pain level was 54/12/26 at 2:00 P.M. pain level was 54/15/26 at 5:00 A.M. pain level was 04/18/26 at 1:37 P.M. pain level 54/24/26 at 6:49 A.M. pain level was 04/24/26 at 11:26 A.M. pain level 34/28/26 at 9:29 A.M. pain level was 64/28/26 at 2:17 P.M. pain level was 6The DON acknowledged the 13 entries on Resident 93's April 2026 MAR for the above dates and times. The DON stated she expected nursing staff to notify the prescriber if a resident is requesting a pain medication when the pain level is outside the parameter. 2. During a concurrent interview and record review of Resident 73's medical record on 4/30/26 at 11:41 A.M. with the DON and Assistant Director of Nursing (ADON), Resident 73's medical record indicated an order for hydrocodone-acetaminophen (a controlled medication used to manage pain) 7.5/325 mg tablet - one tablet every 6 hours as needed for moderate to severe pain (4-10 level pain), dated 4/15/26. Resident 73 received doses on two occasions, as documented on her April 2026 MAR, despite having a pain level of 0 (no pain) on the following dates:4/17/26 at 9:38 A.M. pain level 04/19/26 at 10:27 A.M. pain level 0The DON acknowledged the documented administrations when pain level was zero on the above dates and times. 3. During a concurrent interview and record review on 4/30/26 at 11:41 A.M. with the DON and ADON, Resident 4's medical record was reviewed. Resident 4's medical record indicated orders for oxycodone-acetaminophen 5/325 mg including the following:oxycodone-acetaminophen 5/325 mg - give one tablet by mouth every 8 hours as needed for moderate to severe pain (4-10 level pain), started 11/19/25 and discontinued on 4/15/26, andoxycodone-acetaminophen 5/325 mg - give one tablet by mouth every 6 hours as needed for moderate to severe pain (4-10 level pain), started 4/15/26 and discontinued 4/24/26.Resident 4 received doses of oxycodone-acetaminophen, as documented on her April 2026 MAR, despite having a pain level of 0 (no pain) on the following dates:4/1/26 at 11:10 A.M. pain level 04/15/26 at 12:21 P.M. pain level 04/23/26 at 8:10 A.M. pain level 0The DON acknowledged the documented administrations when pain level was zero on the above dates and times. A review of the facility's P&P titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in accordance with prescriber orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe and effective prescription labeling when a portion of both a prescription label and the handwritten date opened were missing on a medication in one of four inspected Medication Carts for Resident 38. This failure had the potential to negatively alter the drug's stability and effectiveness and for Resident 38 to experience adverse health outcomes.Findings:During a concurrent observation and interview on 4/27/26 at 9:11 A.M. with Licensed Nurse (LN) 33, an inspection of the Station 1 Medication Cart 2 was conducted. Two plastic bags containing foil pouches of ipratropium-albuterol (a medication used to treat respiratory conditions) nebulizer (a device that changes a liquid medication into an inhalable mist) vials for Resident 38 were found. The prescription label on one of the plastic bags was observed to be missing part of the label which provided the directions for using the medication. LN 33 acknowledged that a portion of the prescription label was missing on that bag. The other bag contained an opened foil pouch of the medication. A handwritten date opened on the back of the foil pouch was observed to have been partially missing. The handwritten date that was intact read, 11/26. The product labeling on the front of the foil pouch instructed, Once removed from the foil pouch, the individual vials should be used within one week. LN 33 was read this and the remaining part of the handwritten date. LN 33 stated the opened pouch needed to be discarded.A review of Resident 38's clinical record indicated an active order for ipratropium-albuterol 0.5-2.5 mg (milligram, unit of measure) per 3 mL (milliliter, unit of measure for volume) - inhale orally every 4 hours as needed for shortness of breath or wheezing (a whistling sound caused by narrowed airways), started 1/24/26.During an interview with the Director of Nursing (DON) on 4/29/26 at 3:11 P.M., the DON stated nursing staff were not to write, touch or rip any prescription label. The DON stated nursing staff were to contact the pharmacy for any prescription labels that were removed. The DON stated nursing staff were to discard and reorder medications if they were unsure about the open date for safety. A review of the facility's policy and procedure (P&P) titled, Labeling of Medication Containers, revised 4/19, indicated, .3. Labels for individual resident medications include all necessary information, such as.h. the expiration date.and i. directions for use.7. Only the dispensing pharmacy can label or alter the label on a medication container or package.A review of the facility's P&P titled, Storage of Medications, revised 11/20, indicated, .4. Drug containers that have missing, incomplete.labels are returned to the pharmacy for proper labeling before storing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to maintain sanitary food storage and food service practices when individual size milk cartons were stored in boxes saturated in standing water inside a refrigerator, and when resident meals were cooked and plated for service without verifying cooking and holding temperatures. This failure had the potential to expose residents to foodborne illness from consuming contaminated beverage cartons and serving food to residents without a verified safe cooking temperature.During an observation and interview on 4/27/26 at 9:30 A.M., the kitchen's dairy refrigerator was inspected with the dietary supervisor (DS). The three-door reach-in refrigerator had approximately one inch of standing water that extended across the entire bottom shelf of the refrigerator. Six large cardboard boxes containing 4-ounce cartons of milk had been spread across three large metal pans that were faced down in the water at the bottom of the refrigerator. The bottom of two large cardboard boxes were saturated with water. Upon inspection of the interior of the two boxes, water had seeped through the cardboard and contacted the exterior surfaces of the milk cartons. The DS acknowledged the water at the bottom of the refrigerator and the wet milk cartons in the two boxes. The DS stated the standing water and wet milk cartons were a sanitation and infection control concern. The DS stated that water had previously pooled on the interior of this refrigerator in the past. During an observation of the dairy fridge and interview on 4/27/26 at 9:53 A.M., the registered dietitian (RD) acknowledged the standing water at the bottom of the refrigerator and the wet cardboard boxes and milk cartons. The RD stated that refrigerator was her problem child and it had to be fixed before. The RD stated standing water was an infection control risk for all residents. A review of the facility's invoice from the refrigerator repair company, dated 4/6/26, indicated the cooler had a history of water filing up on the bottom of the cabinet. A review of the facility menu indicated zesty lasagna, Italian green beans, garlic bread, and a peanut butter cookie were to be served for lunch on 4/28/26. 2. During an observation of lunch prep and tray line service on 4/28/26 at 11:17 A.M., the facility chef (FC) placed metal bins full of prepped food in the warming trays and the FC removed the plastic wrap covering each container. At 11:46 A.M., tray line service began and FC began to plate resident diets for meal service. FC did not take the temperature of any meal item on the warming tray before beginning to plate resident meals. The FC continued to plate resident meal trays and loaded two meal delivery carts for distribution without checking the holding temperature of the food in the warming trays. During an interview on 4/28/26 at 11:56 A.M., The FC stated temperatures of all menu items were supposed to be taken and recorded in the temperature log before serving the residents. The FC stated she had not taken the temperature of any meal items after cooking or before serving and therefore did not record anything in the temperature log. FC stated it is important to take the temperature of the food to make sure it is safe for the residents to eat. During an interview and record review of the food temperature log on 4/28/26 at 12 P.M., the registered dietician (RD) stated there were no temperatures recorded for lunch meal item in the temperature log. The RD stated meal item temperatures should be taken before serving to ensure food is safe to serve to residents. The RD stated that undercooked food created a risk of foodborne illness for all residents.During an interview on 4/30/26 at 3:34 P.M., the director of nursing stated the facility should have contacted maintenance about the standing water in the refrigerator and stopped using that particular fridge. The DON stated it was an infection control concern for food items to be sitting in standing water. The DON stated food being served to residents needs to reach a certain temperature criteria to ensure it is safe. The DON stated she expects staff to take the temperature of all food before serving. A review of the facility policy titled, MEAL SERVICE, dated 2023, indicated, Policy: Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner, and served at appropriate temperatures. 2. The Food and Nutrition Services staff member will take the food temperatures prior to service of the meal with a thermometer. 3. The food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will be served on trayline at the recommended temperatures . and recorded on the daily therapeutic menu in the temperature column. of each food served.