

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055957	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Santa Paula Post Acute Center		STREET ADDRESS, CITY, STATE, ZIP CODE 250 March Street Santa Paula, CA 93060	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure safe and sanitary cleaning of dishes and storage practices in the kitchen when: Clean plastic mugs were stored upside down on a tray, with the rims in contact with standing water. An expired bottle of Cayenne Pepper Hot spice was found on the shelf with an expiration date of 3/10/26. These failures had the potential to allow viruses and bacteria to grow and put the residents at risk of developing food borne illnesses (any illness resulting from eating contaminated/spoiled foods). Findings: 1. During a concurrent observation and interview on 7/6/26 at 2:50 PM with the Lead Kitchen Staff (LKS) at the kitchen's drying area, clean plastic mugs were stored upside down on a tray, with the rims in contact with standing water. When interviewed, the LKS stated the mugs were not considered clean. The LKS then proceeded to remove the tray of mugs and further stated that they should be drying on an open rack to properly dry. During a concurrent interview and record review on 7/8/26 at 9:28 AM with the certified Dietary Service Supervisor (DSS), the facility's undated Dishwashing policy and procedure (P&P) was reviewed. The P&P indicated, under .Procedure: 5. Dishes are to be air dried in racks before stacking and storing. The DSS stated that mugs being air-dried should not be sitting in water, to be considered clean and sanitized. During an interview on 7/8/26 at 9:44 AM with the Registered Dietician (RD), the RD confirmed mugs touching standing water on a tray were not considered clean. The RD further stated that dishes being air-dried should not be sitting in water. 2. During a concurrent follow-up kitchen observation and interview on 7/6/2026 at 3:10PM with the LKS, an expired bottle of Cayenne Pepper Hot spice was found on the shelf with an expiration date of 3/10/26. The LKS stated it needed to be thrown out as the facility did not use expired food items. During a concurrent interview and record review on 7/8/2026 at 9:28 AM with the DSS, the facility's undated P&P titled Storage of Food and Supplies was reviewed. The P&P indicated .Procedures for Dry Storage: 8. No food will be kept longer than the expiration date on the product. The DSS stated expired food items needed to be immediately discarded to not cause any harm to residents. During an interview with the RD on 7/8/2026 at 9:44 AM, the RD stated I expect that we have no expired food items or spices in the kitchen.		

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Advance Directive (a written document specifying an individual's medical care wishes) process was completed according to the facility's policies and procedures (P&P) when: 1. There was no documented evidence indicating that 11 of 20 sampled residents (Residents 2, 4, 6, 7, 10, 19, 26, 37, 47, 58, and 91) who had not executed an Advance Directive were offered assistance to formulate one and whether such assistance was accepted or declined. 2. There was no documented evidence indicating that two of 20 sampled residents (Residents 42 and 43) were provided with written information of their rights to formulate an Advance Directive upon admission. This deficient practice had the potential to result in residents not having their health care wishes known, honored, or available during emergent medical situations. Findings: 1a. A review of Resident 2's admission Record, (front page of the chart that contains a summary of basic information about the resident) dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 2's History and Physical (a medical document detailing a patient's current health status and medical background), dated 2/3/26, indicated Resident 2 had the capacity to understand and make decisions. A review of Resident 2's Advance Directive Acknowledgment form, dated 2/9/26, indicated a mark next to the statement I HAVE NOT executed ?Advance Directive. Further review of Resident 2's medical record showed no documented evidence indicating the resident was offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined. b. A review of Resident 4's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE]. A review of Resident 4's History and Physical, dated 3/12/26, indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4's Advance Directive Acknowledgment form, dated 10/7/25, indicated a mark next to the statement I HAVE NOT executed ?Advance Directive. Further review of Resident 4's medical record showed no documented evidence indicating the resident or representative was offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined. c. A review of Resident 6's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 6's History and Physical, dated 3/23/26, indicated Resident 6 did not have the capacity to understand and make decisions. A review of Resident 6's Advance Directive Acknowledgment form, dated 4/16/25, indicated a mark next to the statement I HAVE NOT executed ?Advance Directive. Further review of Resident 6's medical record showed no documented evidence indicating the resident or representative was offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined. d. A review of Resident 7's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 7's History and Physical, dated 5/1/26, indicated Resident 7 had the capacity to understand and make decisions. A review of Resident 7's Advance Directive Acknowledgment form, dated 10/15/25, indicated a mark next to the statement I HAVE NOT executed ?Advance Directive. Further review of Resident 7's medical record showed no documented evidence indicating the resident was offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined. e. A review of Resident 10's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE] and readmitted on [DATE]. A review of Resident 10's History and Physical, dated 6/23/26, (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	decisions. A review of Resident 91's Advance Directive Acknowledgment form, dated 4/1/26, indicated a mark next to the statement I HAVE NOT executed ?Advance Directive.'Further review of Resident 91's medical record showed no documented evidence indicating the resident was offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined.2a. A review of Resident 42's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE].A review of Resident 42's History and Physical, dated 6/12/26, indicated Resident 42 had the capacity to understand and make decisions. Further review of Resident 42's medical record showed no documented evidence an Advance Directive Acknowledgment form was completed. b. A review of Resident 43's admission Record, dated 7/9/26, indicated the resident was initially admitted to the facility on [DATE].A review of Resident 43's History and Physical, dated 6/22/26, indicated Resident 43 had the capacity to understand and make decisions. Further review of Resident 43's medical record showed no documented evidence an Advance Directive Acknowledgment form was completed.A review of the facility's Advance Directive Log 2025 indicated the following:-The Advance Directive information was handed out to Resident 6 on 11/4/25.-The Advance Directive information was handed out to Resident 7 on 4/15/24.-The Advance Directive information was handed out to Resident 37 on 5/29/25.-The Advance Directive information was handed out to Resident 47 on 12/10/25.-The Advance Directive information was handed out to Resident 58 on 7/17/25.Residents 2, 4, 10, 19, 26, 42, 43, and 91 were not listed in the log, and there was no documented evidence indicating the residents were offered assistance to formulate an Advance Directive and whether the assistance was accepted or declined. During an interview on 7/8/2026 at 3:14 PM with the Social Services Director (SSD), the SSD was asked to explain the Advance Directive process. The SSD explained that during the initial assessment, residents were asked whether they had an Advance Directive or Durable Power of Attorney (DPOA - a legal document that lets a person name someone he or she trusts to make medical, legal, or financial decisions when he or she becomes unable to make decisions). The SSD stated if the residents indicated they did not have one, the facility provided and reviewed the form with them. The SSD further stated she would go through the process of completing the form and assisted the residents as needed. During an interview on 7/9/26 at 9:14 AM with the admission Director (AD), the AD stated if residents selected I have not executed an Advance Directive, it meant the residents did not have it and may either choose to formulate one or decline. The AD further stated Social Services was responsible for completing the remainder of the process. During a concurrent interview and record review on 7/9/26 at 10:05 AM with the Social Services Assistant (SSA), Residents 2, 4, 6, 7, 10, 19, 26, 37, 42, 43, 47, 58, and 91's medical records and Advance Directive Acknowledgement forms were reviewed. When asked whether the facility documented Advance Directive offers, acceptances, or declinations in the medical record, the SSA stated the facility documented on paper or electronically. The SSA verified the above findings and acknowledged there was no documented evidence the residents reviewed were offered assistance to formulate an Advance Directive and whether such assistance was accepted or declined. The SSA also acknowledged that Resident 42 and 43 did not have completed Advance Directive Acknowledgment forms. A review of the facility's policy and procedure titled Advance Directives, revised September 2022, indicated .1. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. 2. The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.5. If the resident is incapacitated and unable to receive information about his or her right to formulate an (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	advance directive, the information may be provided to the residents legal representative.If the Resident Does not have an Advance Directive.1. If the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident or representative is given the option to accept or decline assistance, and care will not be contingent on either decision. k. Nursing staff will document in the medical record the offer to assist and the residents decision to accept or decline assistance. 8. Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.15. The interdisciplinary team will review annually with the resident his or her advance directives to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded in the medical record.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 medications and medical supplies were properly labeled and stored when:1. Expired medications and medical supplies remained in the active medication storage areas in one of one Medication Room; and2. A resident-owned (Resident 31) medication with an unreadable expiration date was stored in one of four medication carts without physician review and authorization, and an insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pen was stored beyond the manufacturer's recommended in-use (opened) period.These failures had the potential for residents to receive expired, ineffective, or unauthorized medications, which could compromise resident safety. Findings:1a. During a concurrent observation and interview on 7/6/26 at 8:49 AM with the Assistant Director of Nursing (ADON), medications and medical supplies stored in the Medication Room were inspected. The Medication Room contained five one-ounce bottles of Skintegrity Wound Cleanser (a wound cleansing solution used to clean wounds before dressing changes), and one eight-ounce bottle of Lubricating Deodorant spray (a skin protectant used to reduce friction and help protect the skin) with expiration dates of 5/31/25 and 8/1/25, respectively. The ADON verified both products were expired. The ADON stated expired medications and medical supplies should not be used after the expiration date, should be removed from active medication storage areas, and discarded in the medication waste container located in the Medication Room. The ADON stated the treatment nurses and central supply staff were responsible for checking the wound care supplies and the medications stored in the medication room weekly and should have identified and removed the expired products.b. During a concurrent observation and interview on 7/6/26 at 9:35 AM with the ADON, the medications stored in the Medication Room were further inspected. The Medication Room contained one opened bottle of Citrucel (methylcellulose, an oral laxative used to treat constipation) with an expiration date of June 2026. The ADON verified the product was expired and stated it should have been discarded.During a concurrent interview and record review on 7/7/26 at 8:47 AM with the Director of Nursing (DON), the DON confirmed the expired medications and medical supplies found in the Medication Room should have been removed from the active medication storage areas because they should not be used after the expiration date and might not maintain their intended effectiveness.A review of the facility's policy and procedures (P&P) titled, Medication Labeling and Storage, dated February 2023, indicated .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .2a. During a concurrent observation and interview on 7/6/26 at 3:34 PM with Licensed Vocational Nurse (LVN) 1, the medications stored in the South Wing Medication Cart were inspected. The medication cart contained one original manufacturer's package of MiraFast Soft Chews (magnesium hydroxide 1200 mg [milligram - unit of measurement], an oral laxative used to relieve constipation) for Resident 31. The manufacturer's expiration date printed on the package had been completely erased and was unreadable. The exterior packaging only displayed the resident's written name and room number. LVN 1 confirmed the expiration date was unreadable, and stated nursing staff were responsible for checking the expiration dates of medications stored in the medication cart.During a concurrent interview and record review on 7/7/26 at 8:47AM with the DON, the DON stated MiraFast was Resident 31's own medication. When asked to review the physician's order, the DON stated there was no physician's order for the medication. The DON (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained that resident-owned medications should be reviewed by the physician, and a physician's order should be obtained before the medication was stored in the medication cart for administration. The DON further stated the nursing staff were responsible for checking expiration dates and removing medications with unreadable or expired expiration dates from the medication cart. A review of the facility's P&P titled, Labeling of Medication Containers, dated April 2019, indicated, .All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations .Any medication packaging or containers that are inadequately or improperly labeled as returned to the issuing pharmacy .Labels for individual resident medications include all necessary information, such as .the prescribing physician's name.the name, strength, and quantity of the drug. appropriate accessory and cautionary statements.the expiration date.and.directions for use . A review of the facility's P&P titled Medications Brought to the Facility by the Resident/Family, dated April 2007, indicated .If a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the director of nursing services and nursing staff, with support of the attending physician and consultant pharmacist, shall check to ensure that.the medications have been ordered by the resident's attending physician, and documented on the physician's order sheet.the contents of each container are labeled in accordance with established policies; and.the contents of each container have been verified by a licensed pharmacist.2b. During a concurrent observation and interview on 7/6/26 at 3:34 PM with LVN 1, the medications stored in the South Wing Medication Cart were further inspected. The Medication Cart contained Resident 67's Insulin Lispro KwikPen (a rapid-acting insulin used to lower blood glucose levels) labeled with an open date of 6/1/26. LVN 1 stated the insulin pen expired 28 days after the open date, and they should have been removed from the medication cart and discarded into the medication waste container.During a concurrent interview and record review on 7/7/26 at 8:58 AM, the DON confirmed Resident 67's Insulin Lispro KwikPen exceeded the manufacturer's recommended 28-day in-use period and should have been removed from the medication cart. The DON stated use of an expired insulin pen could result in elevated blood glucose levels and hyperglycemia symptoms (high blood sugar symptoms such as constant thirst, frequent urination, etc.) because the medication might not maintain its intended effectiveness.A review of the manufacturer's package inserts (a document included in the package of a medication that provides information about the drug and its use), dated June 2025, indicated .When stored at room temperature, Insulin Lispro can only be used for a total of 28 days, including.in-use (opened) storage time.Do not use Insulin Lispro past the expiration date printed on the label or 28 days after you first use it.Throw away all opened vials after 28 days of use, even if there is insulin left in the vial.A review of the facility's P&P titled Medication Labeling and Storage, dated February 2023, indicated .Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately assess one of nine sampled residents (Resident 19) when the Minimum Data Set (MDS - a standardized assessment tool) assessment indicated Resident 19 was using anticoagulants (medications that stop the blood from clotting too easily) but did not have any physician orders for anticoagulant medications. This had the potential for inappropriate plan of care for Resident 19. Findings: A review of Resident 19's admission Record, dated 7/9/26, indicated Resident 19 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it). A review of Resident 19's Order Summary Report, dated as of 7/9/26, indicated Resident 19 had no physician's order for anticoagulant medications. During a concurrent interview and record review on 7/9/26 at 1:13 PM with the MDS Coordinator (MDSC), Resident 19's MDS Section N - Medications, dated 6/9/26, was reviewed. The MDS Section N indicated Resident 19 was assessed as taking anticoagulant medications. The MDSC stated Resident 19 is not taking anticoagulant medications and should have not be assessed as using one. The MDSC stated that the assessment did not reflect Resident 19's high-risk medication use, further stating that all resident assessments should be accurate. A review of the facility's Policy and Procedure titled, Resident Assessments, revised March 2022, indicated .8. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide grooming services to one of nine sampled dependent residents (Resident 84), when Resident 84 was observed with untrimmed and dirty fingernails on both hands. This had the potential for skin problems and infection around the nail bed. Findings: A review of Resident 84's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), dated 7/9/26, indicated Resident 84 was admitted on [DATE] with diagnoses that included unspecified symptoms and signs involving cognitive functions and awareness (a medical classification used when a patient exhibits unclassified cognitive, memory, or awareness deficits). A review of Resident 84's History and Physical (a medical document detailing a patient's current health status and medical background), dated 7/8/25, indicated Resident 84 did not have the capacity to understand and make decisions. A review of Resident 84's Minimum Data Set (MDS - a standardized assessment tool) Section E - Behavior assessment, dated 4/27/26, indicated Resident 84 refused Activities of Daily Living (ADL - routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves) assistance, but not on a daily occurrence. A review of Resident 84's MDS Section GG - Functional Abilities assessment, dated 4/27/26, indicated Resident 84 required partial or moderate assistance for personal hygiene (daily habits and practices to maintain cleanliness and overall health). During an observation on 7/6/26 at 10:52 AM, inside Resident 84's room, Resident 84 was observed with untrimmed and dirty fingernails on both hands. During an interview on 7/9/26 at 10:00 AM with the Director of Staff Development (DSD), the DSD stated the facility provided grooming services, including nail care to residents during the weekends. The DSD further stated that if any resident refused care, the licensed nurse would document the refusal. During a concurrent interview and record review on 7/9/26 at 12:03 PM with the Director of Nursing (DON), Resident 84's Progress Notes (PN) were reviewed. The DON confirmed there was no documentation indicating Resident 84 refused nail trimmings, nor was there any documentation that the service was regularly offered to the resident, as scheduled every weekend. The DON stated Resident 84 had the right to refuse, but the facility should continue to offer as necessary. A review of the facility's policy and procedure titled Fingernails/Toenails, Care of, revised February 2018, indicated . The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. Documentation. The following information should be recorded in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual(s) who administered the nail care. 4. Any difficulties in cutting the resident's nails.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nutritional care and services for one of two sampled residents (Resident 12) when Resident 12 had a significant weight loss of 10.31% within three months. This had the potential for Resident 12's nutritional needs and goals to be unmet. Findings: During a review of Resident 12's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), dated 7/9/26, the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm (medical term for cancer) of gallbladder (a small organ under the liver that stores bile [a thick, greenish-yellow fluid that breaks down fatty food] which aids in digestion) and nutritional anemia (a condition where the body lacks enough healthy red blood cells to effectively carry oxygen to the tissues). During a review of Resident 12's Weights and Vitals Summary, with the effective date range from 10/8/25 to 7/8/26, the summary indicated Resident 12 lost 13 lbs. (lbs - an abbreviation for pounds, a unit of weight), from 126 lbs. to 113 lbs. within three months (from 10/8/25 to 1/2/26). During an interview on 7/8/26 at 3:17 PM with the Registered Dietitian (RD), the RD stated one of her responsibilities is to monitor the residents' weights in the facility and address significant weight changes. RD stated significant weight changes included 7.5% or more weight loss in three months. RD stated that Resident 12 lost 13 lbs. from 10/8/25 to 1/2/26 which accounted for 10.31% weight loss in three months. RD confirmed the weight loss within those three months was not reviewed. RD further stated she should have looked into the weight loss for appropriate interventions. During an interview on 7/8/26 at 3:32 PM with the Director of Nursing (DON), the DON stated Resident 12 was diagnosed with cancer and was being treated with radiation therapy, both of which contributed to the weight loss. The DON stated Resident 12's 10.31% weight loss within three months should have been addressed even if it was an expected outcome. A review of the facility's policy and procedure (P&P) titled Weight Assessment and Intervention, revised March 2022, indicated . Weight Assessment. 5. The threshold for significant unplanned and undesired weight loss will be based on the following criteria. b. 3 months - 7.5% weight loss is significant; greater than 7.5% is severe. A review of the facility's P&P titled Nutritional Assessment, revised October 2017, indicated . As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission. and as indicated by a change in condition that places the resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure continuous oxygen therapy was administered as ordered for one of one sampled resident (Resident 91). This failure had the potential to place Resident 91 at risk for hypoxemia (low levels of oxygen in the blood) and respiratory compromise (a dangerous state where breathing or gas exchange is impaired) which could lead to other serious health complications. Findings: During an initial tour observation on 7/7/26 at 8:24 AM inside Resident 91's room, Resident 91 was in bed eating breakfast. The oxygen concentrator (a medical device that pulls in regular room air, removes nitrogen, and delivers purified oxygen) at Resident 91's bedside was powered on and set at three liters per minute, but the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) was not connected to the resident. During a concurrent observation and interview with the Assistant Director of Nursing (ADON) on 7/7/26 at 8:24 AM inside Resident 91's room, the ADON verified the nasal cannula was not applied to the resident. The ADON stated that Resident 91 had a physician's order to receive continuous oxygen at three to five liters per minute. The ADON explained that Resident 91 recently returned from the bathroom, and oxygen had not been reapplied. The ADON then checked Resident 91's oxygen level using a pulse oximeter (a device that measures the heart rate and oxygen level in the blood) which showed an oxygen saturation of 85%. The ADON acknowledged that Resident 91 should have been receiving oxygen and reapplied the nasal cannula. The ADON confirmed portable oxygens were available for residents when using the bathroom to ensure oxygen was administered continuously. However, the ADON confirmed there was no portable oxygen available in Resident 91's room. During a concurrent interview and record review on 7/8/26 at 8:28 AM with Director of Nursing (DON), Resident 91's physician's order dated 2/3/26 was reviewed. The DON acknowledged the physician's order required continuous oxygen administration at three to five liters per minute via nasal cannula and that staff were expected to ensure oxygen was administered as ordered. A review of Resident 91's admission Record (front page of the chart that contains a summary of basic information about the resident), dated 7/8/26, indicated the resident was admitted to the facility on [DATE] with diagnosis that included Chronic Respiratory Failure (a long-term condition where the lungs cannot properly oxygenate the blood or clear carbon dioxide). A review of Resident 91's Order Summary Report, dated as of 7/9/26, indicated Resident 91 had an order for continuous oxygen at three to five liters per minute via nasal cannula to keep the oxygen saturation above 92% every shift. A review of the facility's Policy and Procedure titled Administering Medications, revised April 2019, indicated .4. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability of controlled substances (CS - medications with a high potential for abuse and dependence) for one of six randomly selected residents (Resident 23) reviewed for CS accountability. The facility's Controlled Drug Record (CDR - inventory records used to document receipt, use, and count of controlled substances) did not correspond with the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). This failure resulted in inaccurate accountability of a controlled substance and had the potential for diversion (controlled substances used by someone other than the resident for whom the medication was prescribed) or misuse of controlled substances and compromised residents' medication therapy and safety. Findings: During a concurrent record review and inspection of the Medication Cart at the North Wing Nursing Station on 7/7/26 at 10:13 AM with Licensed Vocational Nurse (LVN) 2, Resident 23's blister card (a type of medicine packaging where individual doses of medication are sealed in small, clear plastic bubbles [blisters] and attached to a rigid card or foil backing) for hydrocodone-acetaminophen (generic for Norco, scheduled II CS used for pain) 5-325 mg (milligram - unit of measurement) and corresponding records were reviewed. A review of Resident 23's physician order, dated 6/21/26, indicated an order for hydrocodone-acetaminophen 5-325mg, give 1 tablet by mouth every 4 hours as needed for pain 7-10/10 (pain scale). A review of Resident 23's CDR, dated 6/30/26 through 7/7/26, indicated the nursing staff removed one Norco 5/325mg tablet from the blister card on 7/2/26 at 9:06 PM and documented the removal in the CDR. A review of Resident 23's July 2026 MAR indicated no corresponding record documenting the administration of the Norco dose removed from the blister card on 7/2/26 at 9:06 PM. The MAR also did not contain a corresponding pain assessment associated with that dose. During a concurrent interview and record review on 7/7/26 at 10:13 AM with LVN 2, LVN 2 confirmed the discrepancy and stated the nursing staff should document the removal of CS in the CDR when the medication is removed from the medication cart. The nursing staff should also document in the MAR after the medication is administered. During a concurrent interview and record review on 7/7/26 at 10:51 AM with the Director of Nursing (DON) in the DON's office, the DON confirmed the discrepancy between the CDR and MAR. The DON stated her expectation was for the nursing staff to document medication administration in the MAR after administering the medication. A review of the facility's policy and procedures titled, Documentation of Medication Administration, dated November 2022, indicated .A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR) .		

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician regarding one of three sampled resident's (Resident 10) chest X-ray (a quick, painless imaging test that uses a small dose of radiation to photograph the heart, lungs, airways, blood vessels, and chest bones) result. This failure had the potential to delay other related physician services that may benefit Resident 10's care. Findings: During a review of Resident 10's admission Record (AR - a document showing a summary of the resident's information), dated 7/9/26, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses that included interstitial pulmonary disease (a broad group of conditions causing progressive inflammation and scarring in the lung tissue), Parkinson's disease (a movement disorder of the nervous system that worsens over time), and unspecified dementia (a progressive state of decline in mental abilities). The AR indicated Resident 10 was under the services of Physician 1. During a review of Resident 10's Progress Notes (PN), dated 5/25/25, the PN indicated Resident 10 was noted with mild nonproductive cough, with a negative result for COVID (a respiratory disease) testing. Physician 1 was notified and provided an order for Resident 10 to receive cough medication as needed every six hours for 14 days. During a review of Resident 10's PN, dated 5/27/26, the PN indicated Resident 10 had an episode of vomiting and generalized weakness. Physician 1 was notified and provided an order for stat (medical term for immediately) chest X-ray. During a review of Resident 10's order summary, dated 5/27/26, the order summary indicated Physician 1 gave an order for stat chest X-ray for Resident 10. During a concurrent interview and record review on 7/9/26 at 12:43 PM with the Director of Nursing (DON), Resident 10's electronic medical record was reviewed. The DON confirmed there was no documentation in Resident 10's electronic medical record that indicated Physician 1 was notified of the chest X-ray result ordered on 5/27/26. The DON further stated Physician 1 should have been notified of the chest X-ray result. During an interview on 7/9/26 at 1:35 PM with Physician 1, Physician 1 stated he was not notified of Resident 10's chest X-ray result. Physician 1 stated the result of the chest X-ray was normal upon review on the day of the transfer to the hospital for further evaluation. Physician 1 stated Resident 10 would still have been transferred unrelated to the X-ray result but still expected to be notified of the result once received. A review of the facility's policy and procedure titled Test Results, revised April 2007, indicated, .The resident's attending physician will be notified of the results of diagnostic tests. 1. Results of laboratory, radiological, and diagnostic test shall be reported in writing to the resident's attending physician or to the facility. 2. Should the test result be provided to the facility, the attending physician shall be promptly notified of the results.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow Infection Prevention and Control Practices when:1. Certified Nursing Assistant (CNA) 1 did not perform hand hygiene after picking up trash from the floor and before assisting with resident care activities, including adjusting the resident's overbed table and obtaining a clean towel. This had the potential to spread microorganisms that can cause healthcare-associated infections.2. Licensed Vocational Nurse (LVN) 3 touched the blood collection tip of a glucose test strip (a disposable plastic or paper strip coated with chemicals that react with the sugar in blood) before obtaining Resident 39's blood specimen and discarded the used blood-contaminated test strip into a regular trash receptacle. These failures had the potential to affect the accuracy of the blood glucose measurement, increase the risk of cross-contamination (the accidental transfer of germs, chemicals, or allergens from one surface, object, or food to another), and result in improper handling of blood-contaminated waste.Findings:1. During an observation on 7/6/26 at 8:56 AM inside room [ROOM NUMBER], CNA 1 picked up trash on the floor with bare hands. CNA 1 then put the trash into the bin, adjusted the overbed table, and removed the meal tray from the resident in Bed B out of the room without performing hand hygiene. CNA 1 then went to get a towel from the clean linen storage without performing hand hygiene. During an interview on 7/6/26 at 9:02 AM with CNA 1, CNA 1 acknowledged she picked trash from the floor then proceeded to adjust the overbed table and remove the meal tray out of the room. CNA 1 also acknowledged she got a towel out from the clean linen storage. CNA 1 stated she did not perform hand hygiene in between any of the tasks she stated. CNA 1 stated she should have performed hand hygiene. During an interview on 7/8/26 at 12:13 PM with the Infection Preventionist (IP), the IP stated all staff are expected to perform hand hygiene in between tasks and further stated that CNA 1 should have put on gloves when picking up trash from the floor. The IP stated that it is an expectation to perform hand hygiene before and after exiting a resident's room. The IP stated CNA 1 should have performed hand hygiene before taking any linen or towel from the clean linen storage. During a review of the facility's Policy and Procedure (P&P) titled Handwashing/Hand Hygiene, revised August 2019, the P&P indicated .Policy Statement.This facility considers hand hygiene the primary means to prevent the spread of infections. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . m. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. q. Before and after assisting a resident with meals. During a review of the facility P&P titled, Personal Protective Equipment- Using Gloves, revised September 2010, the P&P indicated . Objectives. 3. To prevent hands from potentially infectious materials. When to use gloves. 4. When cleaning potentially contaminated items; and 5. Whenever in doubt. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a medication administration observation on 7/6/26 at 11:37 AM, LVN 3 prepared the equipment to monitor Resident 39's blood glucose, including an Assure Platinum Blood Glucose Meter (glucometer - a portable device used to measure blood glucose levels) and Assure Platinum Blood Glucose Test Strips (disposable strips inserted into the glucometer to collect a small blood sample to measure blood glucose levels). During a concurrent observation on 7/6/26 at 11:49 AM, immediately before obtaining Resident 39's blood specimen, LVN 3 touched the blood collection tip of the glucose test strip that was already inserted into the glucometer, with a gloved hand. LVN 3 then performed a fingerstick (process of pricking the tip or side of a finger to draw a small drop of blood for testing) on Resident 39's left index finger, wiped the first drop of blood with a tissue, obtained a second drop of blood, and collected the blood specimen onto the previously touched blood collection tip of the glucose test strip. After completing the blood glucose test, LVN 3 removed the used glucose test strip from the glucometer with a gloved hand. LVN 3 then discarded the used blood-contaminated glucose test strip, the blood-contaminated tissue used to wipe the first drop of blood, and the used gloves into the regular trash receptacle located in Resident 39's room. During a concurrent observation and interview on 7/6/26 at 12:34 PM with LVN 3, the used glucose test strip wrapped in tissue and gloves were observed inside the regular trash receptacle located in Resident 39's room. LVN 3 confirmed touching the blood collection tip of the glucose test strip and stated he did so to ensure it was securely inserted into the glucometer. When asked whether touching the blood collection tip was appropriate, LVN 3 stated he was unsure and would verify the proper procedure. When asked about the proper disposal of the used glucose test strip, LVN 3 pointed to the sharps container (a designated, puncture-resistant container used to safely dispose of contaminated needles and other medical waste) attached to the medication cart and stated either the sharps container or the regular trash receptacle could be used. LVN 3 stated he would verify the proper disposal procedure. During an interview on 7/7/26 at 8:12 AM, LVN 3 stated the blood collection tip of the test strip should not be touched because doing so could alter the integrity of the blood specimen. LVN 3 also stated the used glucose test strip should be discarded into a biohazard (a potentially infectious material) container, such as the sharps container. During an interview on 7/7/26 at 9:01 AM with the Director of Nursing (DON), the DON stated touching the blood collection tip of the glucose test strip could affect the accuracy of the blood glucose result and had the potential for cross-contamination, even while wearing gloves. The DON stated nursing staff should not touch the blood collection tip of the glucose test strip. The DON stated the used glucose test strip should be discarded in a biohazard container, such as the sharps container. During an interview on 7/7/26 at 11:55 AM with the IP, the IP stated the blood collection tip of the glucose test strip should not be touched because microorganisms on gloved hands could contaminate the blood collection surface, alter the accuracy of the blood glucose result, and introduce microorganisms into the resident's fingerstick site during blood specimen collection. The IP also stated blood was considered a biohazard. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/7/26 at 12:08 PM with the Assistant Administrator (AA) and the IP, the manufacturer's instructions were reviewed. The AA stated the manufacturer's instructions indicated disposal of used glucose test strips should follow the facility's policies and procedures. The AA and IP confirmed the facility's policy directed staff to discard disposable supplies in the designated containers. The AA acknowledged blood was considered a biohazard. A review of the manufacturer's manual titled Assure Platinum Blood Glucose Monitoring System Quality Assurance/Quality Control Reference Manual, dated October 2024, indicated: .To reduce the chance of infection.Before performing a blood glucose test, observe the following safety precautions: All components that come into contact with blood samples should be considered to be biohazards capable of transmitting viral diseases between patients and healthcare professionals. .Remove the test strip by holding the meter so that the test strip points down. Push the test strip release button forward. Dispose of test strip. .Dispose of the used Assure Platinum Test Strip and lancet (a small, single-use needled used to prick the skin to obtain a blood sample for blood glucose testing) after the test is performed in the appropriately marked containers or follow your facility's printed policy of disposal for this type of matter. A review of the facility's P&P titled Obtaining a Fingerstick Glucose Level, dated October 2011, indicated .Discard disposable supplies in the designated containers . A review of the facility's P&P titled Blood or Body Fluids Exposure, dated July 2016, indicated: .All blood .should be considered potentially infectious at all times . A review of the facility's P&P titled Standard Precautions, dated September 2022, indicated .Standard precautions (infection prevention practice used for all residents to prevent the spread of infection) presume that all blood .may contain transmissible infectious agents .Resident-care equipment soiled with blood.are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments .Single use items are properly discarded . A review of the facility's P&P titled Biohazard Labeling, dated July 2016, indicated .Materials contaminated with blood or body fluids shall be labeled and discarded appropriately .All wastes containing blood or body fluids will be identified by a red bag, Biohazard (potentially infectious materials) tab, label, or sign .The primary purposes of identifying and labeling biohazardous waste are to warn about possible occupational exposure and to prevent accidental injury or illness to hazardous or potentially hazardous materials .All inquiries concerning the identification of biohazards should be referred to the infection preventionist (or designee) . A review of the facility's P&P titled Medical Waste, Categories of, dated May 2012, indicated .Medical (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wastes from this facility are categorized into the following classifications .human blood . A review of the facility's P&P titled Medical Waste - Preparing for Pickup, dated May 2012, indicated .Medical waste generated by this facility will be segregated from general waste .Medical waste may not be discarded with general trash .Designated individual will be responsible for separating (to the extent practical) medical waste generated by this facility into the following groups .Other regulated medical waste (e.g., blood-soaked bandages .) .Medical waste will be discarded into designated containers (e.g., red bag or container marked with the biohazard symbol) .		