STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056214	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Rehabilitation and Post Acute Care Center	485 W. Johnston Avenue Hemet, CA 92543

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 food preparation and storage practices were followed in accordance with professional standards of practice, when:1. The convection oven had splattered, solidified greasy residue on the glass doors and black crusted residue at the bottom of the oven; and2. One opened package of white loaf bread with a date of January 30, 2026, was found stored on the shelf, readily available for use. The opened package of the white loaf bread did not have an open date and a use-by date.These failures had the potential to cause foodborne illnesses (stomach illness resulting from ingestion of contaminated food) in a medically vulnerable population.Findings:1. On February 9, 2026, at 9:05 am, an initial tour of the kitchen was conducted with the Dietary Supervisor (DS). The convection oven had solidified greasy residue on the glass doors and black crusted residue at the bottom of the oven. In a concurrent interview with the DS, he stated the convection oven was cleaned once a week with a degreaser.On February 13, 2026, at 12:07 p.m., the Registered Dietician (RD) was interviewed. The RD stated the expectation was for the kitchen staff to follow the cleaning schedule. The RD stated the kitchen equipment should be kept clean and in sanitary condition.A review of the facility policy and procedure titled, RANGES AND OVENS, dated, 2023, indicated, .OVENS.CLEANING PROCEDURE.Weekly, and as often as necessary.According to the Food and Drug Administration (FDA - agency responsible for protecting public health by ensuring the safety of the food supply) Food Code 2022, Section 4-601.11, titled, Equipment, Food-Contact Surfaces, Non-Food-Contact Surfaces, and Utensils, indicated, .NONFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris , and Section 4-602.13, titled, Nonfood-Contact Surfaces, indicated, NONFOOD-CONTACT SURFACES OF EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues.2. On February 9, 2026, at 9:05 am, an initial tour of the kitchen was conducted with the DS. One opened package of white loaf bread with a date of January 30, 2026, was found stored on the shelf, readily available for use. The opened package of the white loaf bread did not have an open date and a use-by date. In a concurrent interview with the DS, he stated the opened package of white loaf bread did not have an open date and a use-by date. The DS stated bread is for good seven days after the package had been opened. The DS stated the kitchen staff should place a label with an open date and a use-by date for food that was already open.On February 13, 2026, at 12:07 p.m., the RD was interviewed. The RD stated the kitchen staff were expected to label all opened foods with an open date and a use-by date.A review of the facility document titled, DRY GOODS STORAGE GUIDELINES, dated 2023, indicated bread shelf life when opened is between five to seven days.A review of the facility policy and procedure titled, LABELING AND DATING FOODS, dated 2023, indicated, .All food items in the storeroom, refrigerator, and the freezer need to be labeled and dated.Newly opened food items will need to be closed and labeled with an open date and used by the date.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and treatment was provided, for four of 97 residents reviewed, when:1.For Resident 51, the facility did not provide ongoing assessment and monitoring for bilateral (both) lower extremities edema (swelling caused by too much fluid trapping in the body's tissues);2. For Resident 104, the facility did not provide ongoing assessment and monitoring for bilateral upper and lower extremities, and low blood pressure;3. For Resident 112, the facility did not notify the physician of the resident's change in level of consciousness; and4. For Resident 55, the facility did not identify, address, and notify the physician of the left elbow skin discoloration on February 10, 2026. These failures had the potential for a delay in treatment and placed the residents at risk of complications.Findings: 1.On February 10, 2026, at 10:25 a.m., Resident 51 was observed sitting at bedside, upright with legs dangling off the bed. Resident 51's bilateral lower extremities (both legs, ankles and feet) were observed with edema. In a concurrent interview with Resident 51, she stated she has a history of bilateral lower extremity edema and a recent blood clot to her right leg. Resident 51 stated she usually takes Lasix (a diuretic prescribed to remove excess water and salt from the body through increased urination) 80 milligrams (mg – unit of measurement). Resident 51 stated her left leg edema had worsened and developed new pain behind the knee/calf of her right leg. Resident 51 stated the nurses would check her lower extremities edema once in a while. On February 12, 2026, at 3:16 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated Resident 51 reported right calf pain approximately 3 days ago. CNA 1 stated she reported it to the charge nurse. On February 13, 2026, at 3:16 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 51 had worsening edema to the right lower extremity. LVN 1 stated she notified the physician and received an order to change Lasix 40 mg to two times a day. LVN 1 stated Resident 51 did not report right lower extremity calf pain. On February 13, 2026, Resident 51's medical record was reviewed. Resident 51 was admitted to the facility on [DATE], with diagnoses which included congestive heart failure (CHF - a chronic, progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing blood to back up and fluid to congest in the lungs, legs, and abdomen) and acute embolism and thrombosis (the formation of a blood clot (thrombus) inside a vessel, while an embolism occurs when that clot—or another object like fat or air—breaks off, travels through the bloodstream, and lodges elsewhere) of the right lower extremity. A review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated January 28, 2026, indicated Resident 51 had a BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact). A review of Resident 51's care plan, date initiated on January 23, 2026, indicated, risk for injury and skin breakdown r/t (related to) edema.site(s): edema to bilateral lower extremities .monitor edema daily.as needed .call MD (medical doctor) if worsening.monitor for acute changes in condition.notify physician if these occur. A review of Resident 51's medical records indicated the following physician orders: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Monitor Both Lower extremities +2 pitting edema to increasing pitting, skin tear, signs of infection, every shift for 14 days, date ordered January 23, 2026, with stop date on February 6, 2026; -Furosemide Oral Tablet 40 MG (Furosemide – generic for Lasix) Give 1 tablet by mouth one time a day for CHF, date ordered January 26, 2026; administered until February 4, 2026; and -Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth two times a day for CHF, date ordered February 4, 2026; administered until February 12, 2026. A review of Resident 51's daily skilled charting indicated the nursing staff did not document status of Resident 51's edema on the following dates: - January 24, 2026; - January 25, 2026; - January 26, 2026; - January 27, 2026; - January 28, 2026; - January 29, 2026; - January 30, 2026; - January 31, 2026; - February 1, 2026; - February 2, 2026; - February 3, 2026; - February 8, 2026; - February 9, 2026; and - February 10, 2026 On February 13, 2026, at 12:21 p.m., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON reviewed Resident 51's care plan and daily skilled charting. The ADON stated Resident 51's edema should have been monitored daily and the expectation was for the nursing staff to follow interventions according to the resident's care plan and physician orders. A review of the facility policy and procedure titled, Skin Assessment, revised December 11, 2022, indicated, .It is the policy of this facility to monitor the resident's skin condition daily.implement interventions when needed to prevent complications.provide documented licensed nurse assessments (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on an as-needed basis.the licensed nurse shall notify the physician for orders and follow-up treatment. the licensed nurse progress notes as to findings and doctor's orders . A review of the facility policy and procedure titled, Resident Examination and Assessment, revised February 2014, indicated, .physical exam.skin.presence of edema.documentation.all assessment data obtained during procedure.reporting.notify physician of any abnormalities . 2. On February 12, 2026, at 8:55 a.m., Resident 104's medical record was reviewed. Resident 104 was admitted to the facility on [DATE], with diagnoses which included severe sepsis (a life-threatening medical emergency caused by the body's overwhelming response to an infection) with septic shock (the most severe, life-threatening stage of sepsis, when a body-wide infection causes extremely low blood pressure and cellular abnormalities). A review of Resident 104's Minimum Data Set (MDS-a resident assessment tool), dated December 9, 2025, indicated Resident 104 had a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact). A review of Resident 104's Nursing admission Screening/History, dated December 2, 2025, indicated, BLE (bilateral lower extremities - both legs), bilateral arms (both arms) +1 (mild swelling caused by a small amount of extra fluid trapped in the body's tissues). A review of Resident 104's daily skilled charting indicated there was no documentation of the status of Resident 104's edema on both lower extremities and arms on December 5 to 15, 2025. A review of Resident 104's daily skilled charting, dated December 16, 2025, indicated, .edema present.BUE (bilateral upper extremities-both arms)/BLE, 4+ very deep pitting, indentation lasts a long time, leg is very swollen. A review of Resident 104's medical records indicated the following physician orders: - Lasix (diuretic prescribed to remove excess water and salt from the body through increased urination) Oral Tablet 40 milligrams (mg – unit of measurement). (Furosemide) Give 40 mg by mouth two times a day for edema (swelling caused by too much fluid trapping in the body's tissues), date ordered December 16, 2025; and - MD (medical doctor) order to send resident to ER (emergency room) for abnormal laboratory results, date ordered December 17, 2025. A review of Resident 104's blood pressure exceptions, indicated Resident 104 had low blood pressures on the following dates: -December 9, 2025: 75/54 mmHg (millimeters of Mercury – unit of measurement); and -December 15, 2025: 72/51 mmHg. Further review of Resident 104's record indicated there was no documented evidence the low blood pressure readings were addressed including notification to the physician for further evaluation and management. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 104's care plan, did not include a plan of care to address the edema on both upper and lower extremities which were present on admission. On February 12, 2026, at 3:09 p.m., an interview was conducted with CNA 1. CNA 1 stated when a CNA identified a systolic blood pressure is less than 120 or diastolic (pressure in your arteries when your heart is resting between beats) blood pressure is less than 80, the CNA should report it to the charge nurse, and the charge nurse would notify the physician. CNA 1 stated Resident 104 had BLE edema since admission and throughout her stay in the facility. CNA 1 stated Resident 104 did not suddenly develop BLE edema. On February 13, 2026, at 9:49 a.m., an interview was conducted with LVN 1. LVN 1 stated some risks for hospitalization would include: if a resident has wounds, long term lung disease or worsening edema. LVN 1 stated to prevent hospitalization the licensed nurse was expected to assess the resident every shift, review the resident's medical record and vital signs (essential measurements of how the body is functioning), then the licensed nurse will notify the physician of any changes in the resident's status. LVN 1 stated the licensed nurse would assess and monitor edema by weekly weights, urine output and increased size of the extremity. LVN 1 stated if edema worsens it is considered a change of condition and the licensed nurse should notify the physician. On February 13, 2026, at 11:30 a.m., a concurrent interview and record review was conducted with the ADON. The ADON reviewed Resident 104's blood pressure, weights and daily skilled charting as listed above. The ADON acknowledged the nursing staff did not follow the facility policy for acute condition changes. The ADON stated Resident 104's blood pressure 72/51 mmHg on December 15, 2025, was considered too low and the licensed nurse should have notified the physician. The ADON stated edema assessment was part of the nursing head to toe assessment. The ADON stated the nursing staff was expected to assess and monitor edema every shift. A review of the facility policy and procedure titled, Resident Examination and Assessment, revised February 2014, indicated, .physical exam.skin.presence of edema.documentation.all assessment data obtained during procedure.reporting.notify physician of any abnormalities.abnormal vital signs. A review of the facility policy and procedure titled, Acute Condition Changes, revised March 2018, indicated, .the physician will help identify individuals.with a significant risk for having acute changes of condition.in addition.the nurses shall assess.document/report.the following baseline information.vitals signs.the staff will monitor and document the resident/patient's progress and responses to treatment.the physician will adjust treatment accordingly. 3. On February 10, 2026, at 10:10 a.m., Resident 112 was observed well groomed, sleeping in bed, calm with head of the bed elevated. On February 10, 2026, at 2:25 p.m., Resident 112 was observed sleeping in bed. Resident 112 was not easily arousable with knocking on the door or calling resident's name while standing next to resident bedside. On February 10, 2026, at 3:05 p.m., Resident 112 was observed sleeping in bed. Resident 112 did not awaken with speaking to the resident. On February 10, 2026, at 3:35 p.m., a concurrent observation and interview was conducted with Speech Therapist (ST) at Resident 112 bedside. The ST was attempting to arouse Resident 112 with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	calling resident's name and gentle touch. Resident 112 was observed opening eyes then falling back asleep. The ST stated she was working with Resident 112 every day for 30 minutes on her swallowing. The ST stated Resident 112 has been sleepy the last couple of days. The ST stated Resident 112 was unable to tolerate thin liquids water. The ST was observed giving Resident 112 nectar thick water. Resident 112 was observed coughing. Resident 112 was observed unable to answer simple questions. On February 11, 2026, at 11:11 a.m., Resident 112's medical record was reviewed. Resident 112 was admitted to the facility on [DATE], with diagnoses which included cognitive functions following cerebral infarction (a person's thinking, memory and reasoning abilities are affected after blockage of blood flow to the brain). A review of Resident 112's Minimum Data Set (MDS - a resident assessment tool), dated October 19, 2025, indicated Resident 112 had a BIMS (Brief Interview of Mental Status) score of 11 (moderate cognitive impairment). A review of Resident 112's, Nursing admission Screening/History, dated January 28, 2026, indicated, .Unarousable/Coma/Persistent Vegetative State.No. The MDS, Section B: Hearing, Speech, and Vision, dated February 4, 2026, indicated Resident 112 was not comatose, persistent vegetative state. A review of Resident 112's Daily Skilled Note indicated Resident 112's level of consciousness as follows: -February 10, 2026: alert, person, place, time, situation; -February 11, 2026: alert person: short term memory impairment, impaired decision-making ability; and -February 12, 2026: alert person place time situation. A review of Resident 112's ST (Speech Therapy) Treatment Encounter Note dated February 11, 2026, at 12:42 p.m., indicated, .with her medication nurse.attempting to arouse her.when therapist came.to work with her today.continues with congestion and coughing.daughter stated may be having a relapse of pneumonia or influenza infection.may need to see the doctor for antibiotics. On February 11, 2026, at 11:54 a.m., Resident 112 was observed sleeping in bed with head of bed elevated. Resident 112 did not awaken to voice. On February 12, 2026, at 3:09 p.m., Resident 112 was observed sleeping in bed. A concurrent observation and interview were conducted with CNA 1. CNA 1 stated Resident 112 baseline level of consciousness was alert and would answer appropriately. CNA 1 stated Resident 112 had been lethargic and confused. CNA 1 stated that she reported to the licensed nurse. On February 13, 2026, at 9:49 a.m., an interview was conducted with LVN 1. LVN 1 stated when a resident was identified with a change in mental status or a resident was observed lethargic or sleepy, the licensed nurse would notify the physician with the change of condition findings. On February 13, 2026, at 12:16 p.m., Resident 112 was observed sleeping in bed, with head of the bed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	elevated. Resident 2 did not awaken to voice or knocking on resident's room door. On February 13, 2026, at 2:32 p.m., a concurrent interview and record review was conducted with the ADON. The ADON reviewed Resident 112's medical record. The ADON stated Resident 112 had dementia (decline in mental ability). The ADON stated Resident 112 had a chest x-ray (imaging test to take pictures inside the body) on February 12, 2026, with conclusion: no acute cardiopulmonary (heart and lungs) process. The ADON reviewed the nursing admission screening. The ADON stated Resident 112's baseline was alert. The ADON stated the expectation was the licensed nurse will assess and monitor the resident mental status and behavior, document on the daily skilled note every shift and report any change in condition from baseline to the physician. A review of the facility policy and procedure titled, Resident Examination and Assessment, revised February 2014, indicated, .physical exam.neurological.alertness and orientation .documentation.all assessment data obtained during procedure.reporting.notify physician of any abnormalities.abnormal change in cognitive, behavioral or neurological status from baseline. A review of the facility policy and procedure titled, Acute Condition Changes, revised March 2018, indicated, .the physician will help identify individuals.with a significant risk for having acute changes of condition.in addition.the nurses shall assess.document/report.the following baseline information.level of consciousness.cognitive status.the staff will monitor and document the resident/patient's progress and responses to treatment.the physician will adjust treatment accordingly. 4. On February 10, 2026, at 11:18 a.m., Resident 55 was observed lying in bed, awake and alert. Resident 55's left elbow was observed with purplish discoloration. In a concurrent interview with Resident 55, she stated she kept bumping her left arm on the side rail. On February 13, 2026, at 10:47 a.m., Resident 55 was observed with Licensed Vocational Nurse (LVN) 2. LVN 2 assessed Resident 55 and stated Resident 55 had a discoloration on the left elbow that was fading. Resident 55 stated she would always bump her elbow on the side rails, and she informed a staff member about it. In a concurrent interview and record review with LVN 2, she stated the nurse would assess, notify the physician, monitor, and document the new skin condition. LVN 2 stated there was no documented evidence Resident 55's left elbow discoloration was identified, assessed, monitored and reported to the physician. On February 13, 2026, at 11:32 a.m., during a concurrent interview and record review with the Treatment Nurse (TN), she stated the CNA should report it to the charge nurse when a new identified skin condition, and the charge nurse would notify the physician. The TN stated the skin discoloration should be monitored as a change of condition. The TN further stated there was no documentation Resident 55's left elbow skin discoloration was identified, assessed, monitored and reported to the physician. Resident 55's medical record was reviewed. Resident 55 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (a severe form of one-sided paralysis) and hemiparesis (a neurological condition characterized by weakness on one side of the body, affecting the arms, legs, and face). A review of the physician's history and physical, dated December 22, 2025, indicated Resident 55 was alert. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 55's Minimum Data Set (MDS – an assessment tool), dated December 28, 2025, indicated a Brief Interview of Mental Status (BIMS – a cognitive assessment tool) score of 15 (cognitively intact). The MDS also indicated Resident 55 did not have any skin conditions. A review of the facility policy and procedure titled, SKIN ASSESSMENT, revised December 11, 2022, indicated, .It is the policy of this facility to monitor the resident's skin condition daily, implement interventions when needed to prevent complications, and provide documented licensed nurse assessments on an as-needed basis .Nursing assistants will check resident's skin every shift and shall report any skin integrity impairment to the licensed nurse for follow-up. The licensed nurse will observe the reported impairment .The licensed nurse shall perform a weekly skin check according to the weekly summary schedule .The licensed nurse shall notify the physician for orders and follow-up treatment. The resident or family will be notified of changes in the resident's skin status .The licensed nurse will make an entry on the resident's care plan as well as the licensed nurse progress notes as to findings and doctor's orders .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with physician orders and the facility's policies and procedures, when a medication error rate of 11.9% was identified, with five medication errors out of 42 medication administration opportunities, during medication pass observations for two of five residents observed (Residents 32 and 47).These failures included administration of incorrect medication, incorrect dosage form, and omissions of ordered medication while documenting them as administered, which had the potential to compromise residents' medication therapy and safety. Findings:1. On February 9, 2026, at 9:53 a.m., during a medication administration observation, Licensed Vocational Nurse (LVN) 3 was observed preparing and administering seven medications to Resident 47, including:- Vitamin C (supplement) 500 mg (milligram - unit of measurement) tablet;- Docusate sodium (stool softener) 100 mg softgel capsule;- Multivitamin with minerals (supplement) tablet;- Vitamin D (supplement) 25 mcg (microgram - unit of measurement) tablet;- Jardiance (used to treat Type II Diabetes) 25 mg;- Xarelto (blood thinner used to prevent blood clots) 15 mg tablet; and- Acidophilus lactobacillus (probiotic supplement) capsule.On February 9, 2026, at 12:57 p.m., a review of Resident 47's physician orders indicated:- There was no physician order for vitamin C 500 mg; and- There was a physician order for cyanocobalamin (vitamin B12 - supplement) 500 mcg, one tablet by mouth daily for supplement, dated [DATE].The ordered cyanocobalamin 500 mcg was not administered to Resident 47 during the observed 9 a.m. medication pass with LVN 3.A review of Resident 47's Medication Administration Record (MAR), dated February 2026, indicated the following:- There was no documentation of vitamin C 500 mg being administered; and- Cyanocobalamin 500 mcg was documented as administered at 9 a.m. on February 9, 2026.On February 9, 2026, at 3:11 p.m., during a concurrent interview and record review with LVN 3, LVN 3 confirmed Resident 47 did not have a physician order for Vitamin C 500 mg but had an order for vitamin B12 500 mcg. LVN 3 acknowledged administering vitamin C 500 mg instead of vitamin B12 500 mcg and stated the error may have occurred because the bottles were similar in size and appearance, both beginning with Vitamin and containing 500 in the strength.2. On February 10, 2026, at 9:23 a.m., during a medication administration observation, LVN 5 was observed preparing and administering 16 medications to Resident 32, including:- Aspirin (used to prevent blood clots) enteric coated (EC - a coating on the drug tablet to protect the stomach and to allow aspirin to pass through the stomach to the small intestine before dissolving) 81 mg tablet;- Carvedilol (used to treat high blood pressure) 6.25 mg tablet;- Divalproex (mood stabilizer) 500 mg delayed-release (DR - designed with a special coating that prevents the medication from dissolving in the stomach and allow it to be released in the intestine) tablet;- Duloxetine (used to treat depression) 20 mg DR capsule;- Hydroxychloroquine sulfate (used to treat autoimmune conditions such as lupus, causing inflammation and pain) 200 mg tablet;- Losartan potassium (used to treat high blood pressure) 50 mg tablet;- Prednisone (steroid used to reduce inflammation) 10 mg tablet;- Quetiapine (antipsychotic medication used to treat mental illness) 50 mg tablet;- Ropinirole (used to treat tremors) 0.5 mg tablet;- Conjugated estrogen (hormone therapy, used to treat hot flashes, menopausal symptoms) 0.3 mg tablet;- CertaVite (vitamins and minerals) tablet;- Docusate sodium 100 mg;- Oxycodone-acetaminophen (narcotic pain medication)10-325 mg tablet;- Levofloxacin (antibiotic used to treat bacterial infection) 500 mg;- Lorazepam (used to treat anxiety) 1 mg; and- Pregabalin (used to treat nerve pain) 150 mg.On February 10, 2026, at 10:04 a.m., a review of Resident 32's physician orders indicated:- Aspirin 81 mg chewable tablet, give one tablet by mouth one time a day for MI/CVA (myocardial infarction [heart attack] and cerebrovascular accident [stroke]), dated [DATE];- Calcium Carbonate (supplement) 500 mg chewable tablet, give one tablet by mouth three times a day for Supplement, dated [DATE]; and- Glycolax (brand name for polyethylene glycol 3350 - used to treat constipation) 17 gm (gram - unit of measurement) / scoop, give 1.5 scoop by mouth one time a day for (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bowel management. Mix 1.5 capfuls with 8 oz (ounce - unit of measurement) of water or juice (25.5 g), dated [DATE].A review of Resident 32's MAR, dated February 2026, indicated the following medications were documented as administered at 9 a.m. on February 9, 2026:- Aspirin 81 mg chewable tablet;- Calcium carbonate 500 mg chewable tablet; and- GlycoLax 17 gm/scoop, 1.5 scoop.On February 10, 2026, at 10:29 a.m., during a concurrent interview and record review with LVN 5, LVN 5 reviewed Resident 32's physician orders and MAR. LVN 5 confirmed:- She had administered aspirin 81 mg enteric-coated tablet instead of the ordered aspirin 81 mg chewable tablet;- Calcium Carbonate 500 mg and GlycoLax were documented as administered at the 9 a.m. medication pass but were not administered; and- There were no medication bottles for Aspirin 81 mg chewable tablet, Calcium Carbonate 500 mg, and GlycoLax available in her medication cart at the time of administration. - She had discarded an expired bottle of GlycoLax earlier that morning and had not replaced it with a new bottle prior to the medication pass.- She acknowledged she should have verified the medication label and the dosage form against the physician's order prior to administration and should not have documented medications as administered when they were not given.- Further stated she may have selected Yes in the electronic MAR for medications scheduled 9 a.m. without verifying each medication prior to documentation.On February 11, 2026, at 10:44 a.m., during an interview with the Director of Nursing (DON), the DON stated the nursing staff are required to follow the Rights of medication administration, including right medication and right dosage form, and must verify the medication label against the MAR during three preparation checks according to the facility's policy and procedures. The DON stated the nursing staff should carefully read medication labels, confirm correct dosage form, and accurately document medications administered in the electronic MAR.A review of the facility's policies and procedures titled, Preparation and General Guidelines, IIA2: Medication Administration - General Guidelines, dated February 2020, indicated, .FIVE RIGHTS.right drug, right dose.are applied for each medication being administered. A triple check of these 4 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.Check #1: Select the Medication - label, container and contents are check for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights.Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights.Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights.Administration.2) Medications are administered in accordance with written orders of the prescriber.Documentation (including electronic) .At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.

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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 were stored in accordance with the facility's policies and procedures and manufacturer's specifications, when:1. An insulin (medication to treat diabetes mellitus [abnormal blood sugar]) pen was stored in the Medication Cart at Nursing Station 3 without documentation of the date removed from refrigeration;2. Two discontinued controlled substances (CS - those with high potential for abuse and addiction) were stored in the Medication Cart at Nursing Station 4 with other active medications; and3. A single-use plastic vial of Levalbuterol inhalation solution was stored without a prescription label, without light protection, and without documentation of the date removed from its protective foil pouch.These failures had the potential to result in residents receiving ineffective, deteriorated, or discontinued medications, leading to medication errors and compromised treatment outcomes. Additionally, the improper storage of discontinued controlled substances had the potential to increase the risk of diversion (medication taken by someone other than the person for whom it was prescribed) or misuse.Findings:1. On February 10, 2026, at 11:31 a.m., during an inspection of Medication Cart at Nursing Station 3 with Licensed Vocational Nurse (LVN) 4, a HumaLOG KwikPen (brand of insulin pen used to treat diabetes) 100 units/3mL (units/mL - unit of measurement) was observed labeled for Resident 19. The insulin pen was stored at room temperature in an opened manufacturer's box (originally containing five pens; one pen remained). There was no date written on the pen to indicate when it had been removed from refrigeration. On February 10, 2026, at 11:31 a.m., during a concurrent interview, LVN 4 stated she was unsure when the insulin pen had been removed from the refrigerator and acknowledged the date of removal should have been written on the insulin pen. On February 11, 2026, at 10:44 a.m., during an interview and record review with the Director of Nursing (DON), the manufacturer's package insert for HumaLOG KwikPen was reviewed. The DON acknowledged that without documentation of the date removed from refrigeration, the 28-day room-temperature stability period could not be accurately determined and stated the unopened insulin pen stored at room temperature without the date should have been discarded. A review of the manufacturer's package inserts for HumaLOG KwikPEN, dated January 2026, indicated: .When stored at room temperature, HUMALOG U-100 .can only be used for a total of 28 days, including both not in-use (unopened) and in-use (opened) storage time. A review of the facility's policies and procedures titled, Medication Storage in the Facility, ID1: Storage of Medications, dated February 2020, indicated, .Medications requiring refrigeration UNTIL OPENED: .Insulin - Once opened should be kept outside of refrigerator.2. On February 10, 2026, at 2:24 p.m., during an inspection of the Medication Cart at Nursing Station 4 with LVN 5, the following discontinued medications were observed stored in the medication cart together with active medications:- A blister card of Ambien (brand name for zolpidem, used to treat insomnia) 5 mg (milligram - unit of measurement), labeled for Resident 79; and - A blister card of Tramadol (narcotic pain medication) 50 mg, labeled for Resident 3.On February 10, 2026, at 2:24 p.m., a review of physician orders indicated:- Resident 79's Ambien 5 mg was discontinued on January 27, 2026, at 12:58 p.m., with the reason documented as ineffective; and- Resident 3's Tramadol 50 mg was discontinued on January 9, 2026, at 6:30 p.m.On February 10, 2026, at 2:24 p.m., during a concurrent observation, interview, and record review with LVN 5, LVN 5 confirmed the medications were discontinued and remained stored in the medication cart. LVN 5 stated the discontinued medications should be marked D/C, removed from the medication cart, and provided to the DON for proper disposal if a controlled substance.On February 11, 2026, at 10:44 a.m., during an interview with the DON, the DON acknowledged discontinued controlled medications should have been removed from the medication cart and secured separately pending destruction. The DON stated it was not acceptable for the Ambien to remain in the cart for approximately two weeks and Tramadol for (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approximately four and a half weeks after discontinuation and confirmed the facility's policy and procedure had not been followed. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, IE3: Discontinued Medications, dated October 2012, indicated, .When medications are discontinued by the prescriber., the medications are marked as discontinued and stored in a secure and separate area from the active medications.Medications are removed from the medication cart.immediately upon receipt of an order to discontinue (to avoid inadvertent administration). Medication awaiting disposal.are stored in a locked secure area designated for that purpose until destroyed.A review of the facility's policy and procedure titled, Medication Storage in the Facility, ID2: Controlled Substance Storage, dated October 2012, indicated, .Controlled substances remaining in the facility after the order has been discontinued.retained in the facility in a securely locked area with restricted access until destroyed. A review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, IE5: Medication Destruction, dated October 2012, indicated, .Discontinued medications.which do not qualify for return to the pharmacy for credit, are destroyed.Unused.non-returnable medications should be removed from their storage area and secured until destroyed.3. On February 10, 2026, at 3:41 p.m., during an inspection of Medication Cart at the Split Nursing Station (between Nursing Station 1 and 2) with LVN 6, one unit-dose plastic vial of levalbuterol (medication used to treat breathing problems such as bronchospasm) 1.25 mg/3 mL (mg/mL - unit of measurement) inhalation solution was observed stored in the top drawer of the medication cart. The vial was outside of its protective foil pouch, had no prescription label, and had no documentation indicating the date it was removed from the foil pouch. On February 10, 2026, at 3:41 p.m., during a concurrent observation and interview, LVN 6 confirmed the vial was stored outside of its foil pouch and acknowledged there was no prescription label to identify which resident it belonged to. LVN 6 also acknowledged that without documentation of the date removed from the pouch, it was unknown how long the vial had been stored outside of light protection and stated it should have been removed from the medication cart and discarded.On February 11, 2026, at 10:44 a.m., during an interview and record review of the manufacturer's package insert for levalbuterol with the DON, the DON acknowledged the medication should have been discarded due to lack of labeling, lack of light protection, and absence of a documented removal date from foil pouch. A review of the manufacturer's package inserts for levalbuterol inhalation solution, dated February 2020, indicated, .Store Levalbuterol Inhalation Solution.in the protective foil pouch at 20 - 25 C (68 - 77 F) .Protect from light and excessive heat. Keep unopened vials in the foil pouch. Once the foil pouch is opened, the vials should be used within 2 weeks. Vials removed from the pouch, if not used immediately, should be protected from light and used within 1 week.A review of the facility's policy and procedure titled, Medication Storage in the Facility, ID1: Storage of Medications dated February 2020, indicated, .Medications.are stored safely, securely, and properly, following manufacturer's recommendations.Outdated, contaminated, or deteriorated medications.are immediately removed from inventory, disposed of according to procedures for medication disposal.Medication storage conditions are monitored on a monthly basis by the consultant pharmacist or pharmacy nurse consultant and corrective action taken if problems are identified.All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure proper infection control practices were implemented for seven out of 97 residents reviewed for infection control practices when:1. For Residents 47 and 108, nursing staff did not clean and disinfect shared medical equipment, including a blood pressure (BP) cuff and stethoscope (medical instrument for listening to the action of someone's heart or breathing, typically having a small disk-shaped resonator that is placed against the chest, and two tubes connected to earpieces), before and after use, in accordance with the facility's infection control policy;2. Certified Nursing Assistant (CNA) 2 did not perform hand hygiene in between serving food trays to four residents in Station 2 during the lunch meal service on February 9, 2026; and3. For Resident 30, CNA 3 did not perform handwashing before and after entering Resident 30's room who required contact isolation precautions for Clostridium Difficile (C - diff - a highly contagious bacteria causing severe diarrhea, fever, and abdominal pain).These failures had the potential to result in the transmission of infectious organisms between residents and compromise residents' health and safety.Findings: 1a. On February 9, 2026, at 9:15 a.m., during a medication administration observation for Resident 108, Licensed Vocational Nurse (LVN) 3 was observed retrieving a BP cuff from the bottom drawer of her medication cart, and entering the resident's room with a stethoscope draped around her neck. LVN 3 was observed not to disinfect the BP cuff and stethoscope before entering Resident 108's room. On February 9, 2026, at 9:18 a.m., LVN 3 was observed using the BP cuff and stethoscope, which had not been cleaned or disinfected, to obtain Resident 108's blood pressure. On February 9, 2026, at 9:22 a.m., after obtaining blood pressure reading, LVN 3 was observed draping the used stethoscope around her neck and placed the used BP cuff into the bottom drawer of the medication cart and keeping the used stethoscope draped around her neck without cleaning or disinfecting the equipment. 1b. On February 9, 2026, at 9:53 a.m., during a medication administration observation for Resident 47, LVN 3 was observed retrieving the same BP cuff from the bottom drawer of her medication cart and entering the resident's room with the same stethoscope draped around her neck. LVN 3 was observed using the same BP cuff and stethoscope, which had not been cleaned or disinfected after prior use, to obtain Resident 47's blood pressure. On February 9, 2026, at 9:57 a.m., after obtaining blood pressure reading, LVN 3 was observed draping the used stethoscope around her neck and placing the used BP cuff back into the bottom drawer of the medication cart without cleaning or disinfecting the equipment. On February 9, 2025, at 3:11 p.m., during an interview with LVN 3, LVN 3 acknowledged the BP cuff and stethoscope were not cleaned or disinfected before and after use between residents. LVN 3 stated the BP cuff and stethoscope are shared equipment and should have been cleaned and disinfected using Sani-Cloth germicidal disposable wipes (disinfectant wipes used to kill bacteria and viruses) available in the medication cart. On February 11, 2026, at 10:44 a.m., during an interview with the Director of Nursing (DON), the DON stated the BP cuff, and stethoscopes are considered shared medical equipment and required to be cleaned and disinfected with disinfectant wipes before and after each use for infection control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevention. A review of the facility's policies and procedures titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated October 2018, indicated, .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard.Non-critical items are those that come in contact with intact skin.Non-critical resident-care items include.blood pressure cuffs.Reusable items are cleaned disinfected.between residents (e.g., stethoscope, durable medical equipment).Durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. 2. On February 9, 2026, at 12:17 p.m., during the lunch meal service at Station 2, CNA 2 was observed dropping off a meal tray in room [ROOM NUMBER], who required Enhanced Barrier Precaution (EBP-an infection control strategy for nursing homes to reduce the spread of multidrug-resistant organisms [MDROs] by requiring the use of gowns and gloves during high-contact resident care), and leaving the room holding a desert bowl, spoon and cup with her bare hands. CNA 2 proceeded to the food cart and placed the desert bowl, spoon and cup on top of food cart. CNA 2 proceeded to pick up one meal tray from inside the food cart and brought the food tray to room [ROOM NUMBER]-B. CNA 2 came out of room with another meal tray and placed the meal tray on top of the food cart. CNA 2 took one meal tray from inside the food cart and proceeded to serve it to room [ROOM NUMBER]-B, an EBP room, and came out of the room holding a plate cover. CNA 2 went to the food cart and placed the plate cover on top of the food cart. CNA 2 took one meal tray from inside the food cart and proceeded to RM [ROOM NUMBER], an EBP room, and came out of room holding a plate cover. CNA 2 was observed to not perform hand hygiene throughout and in between serving the residents. CNA 2 was stopped in the hallway and was interviewed. CNA 2 confirmed she did not perform hand hygiene in between serving the food trays to the residents. CNA 2 stated the staff should observe hand hygiene between provision of care to residents. CNA 2 stated, I guess in between every patient. CNA 2 further stated she should have performed hand hygiene in between passing trays to the residents. On February 9, 2026, at 3:26 p.m., the Infection Preventionist (IP) was interviewed. The IP stated her expectation was for staff to perform hand hygiene before and after patient care and between patients. The IP stated passing trays were part of patient care, and staff should wash hands or perform hand hygiene with ABHR (alcohol-based hand rub) in between passing trays. The IP stated CNA 2 should have performed hand hygiene in between serving meals trays. A review of the facility's policy and procedure titled, Handwashing/Hand Hygiene, revised August 2019, indicated, .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors .Use an alcohol based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations .before and after direct contact with residents .After contact with objects .within (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the immediate vicinity of the resident .Before and after entering isolation precaution settings .Before and after assisting a resident with meals . 3. On February 9, 2026, at 3:14 p.m., a contact isolation sign for C-diff was observed posted by the door for Resident 30. Resident 30 was observed lying in bed and stated he was doing alright. On February 9, 2026, at 3:30 p.m., Certified Nursing Assistant (CNA) 3 was observed to don (to put on) personal protective equipment (PPE – equipment worn to minimize exposure to hazards and/or illnesses. Examples: gloves, gown and mask) and entered Resident 30's room. On February 9, 2026, at 3:38 p.m., CNA 3 was observed doff (to remove) the PPEs, went out of Resident 30's room and used the hand sanitizer. CNA 3 was observed to get a diaper from the linen cart, don PPEs and went back inside Resident 30's room. On February 9, 2026, at 4:11 p.m., during an interview with CNA 3, she stated she used the hand sanitizer when she came out of Resident 30's room. CNA 3She also stated she did not wash her hands with soap and water when she took a clean diaper from the linen cart and re-entered Resident 30's room. On February 13, 2026, at 12:45 p.m., during an interview with the Infection Preventionist (IP), she stated she expected the staff to follow the C-diff contact precaution, which was to wash hands with soap and water before entering and after leaving the resident's room who was on C-diff isolation. The IP stated CNA 3 should have washed her hands with soap and water before and after she entered Resident 30's room. Resident 30's record was reviewed. Resident 30 was admitted to the facility on [DATE], with diagnoses which included enterocolitis (inflammation of both the small intestine and colon [large intestine]). A review of Resident 30's laboratory examination for stool culture on January 19, 2026, indicated a positive result for Clostridium Difficile toxins (poisonous, typically protein-based substances that cause disease upon contact or absorption). A review of the facility policy and procedure titled, Clostridium Difficile, revised October 2018, indicated, .Measures are taken to prevent the occurrence of Clostridium difficile infections (CDI) among residents. Precautions are taken while caring for residents with C. difficile to prevent transmission to others.Spores can persist on resident-0care items and surfaces for several months an are resistant to some common cleaning and disinfection methods.Steps toward prevention and early intervention include.frequent hand washing with soap and water by staff and residents.When caring for residents with CDI, staff is to maintain vigilant hand hygiene. Handwashing with soap and water is superior to ABHR (alcohol- based hand rub) for the mechanical removal of C. difficile spores from hands.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician evaluated and documented the clinical rationale supporting the continued use of the as-needed (PRN) lorazepam (a psychotropic medication used to treat anxiety) beyond 14 days, for one of five residents reviewed for unnecessary psychotropic (drug that affects brain activities associated with mental processes and behaviors) medications (Resident 28).This failure had the potential to result in unnecessary use of psychotropic medications and increased risk for adverse effects, including sedation, confusion, and falls. Findings:On February 12, 2026, a review of Resident 28's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses including anxiety disorder, Alzheimer's disease (progressive memory loss, a type of dementia), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a psychotic disorder characterized by a loss of contact with reality), and insomnia (difficulty sleeping).A review of Resident 28's Care Plan Report, initially dated September 24, 2025, and revised February 13, 2026, indicated: . (Resident name) at Risk for adverse side effects and for mood concerns related to dx (diagnosis) anxiety and r/t (related to) antianxiety medication usage: Lorazepam as ordered. IDT (interdisciplinary team - a group of healthcare professionals) will continue to assess ongoing alternative or need for this medication and monitor for any adverse side effects or any concerns related to moods/behaviors. She has episodes of crying when confused and anxious.A review of Resident 28's Physician orders indicated the following PRN lorazepam orders:- On March 7, 2025, lorazepam 0.5 mg (milligram - unit of measurement), one tablet by mouth every 6 hours as needed for anxiety/restless or agitation, was ordered and remained active until May 27, 2025;- On July 17, 2025, lorazepam 0.5mg, one tablet by mouth every six hours as needed for anxiety, was ordered and remained active until September 26, 2025;- On September 26, 2025, the PRN order was renewed at the same dose and frequency, with the indication revised to anxiety manifested by crying out, and remained active until December 17, 2025;- On December 17, 2025, the PRN lorazepam order was renewed at the same dose and frequency with a specified duration of 14 days for anxiety manifested by crying out, and remained active until December 31, 2025; and- On January 8, 2026, the PRN lorazepam order was reordered at the same dose and frequency, with the indication revised to anxiety manifested by restlessness, and remained active at the time of survey.A review of Resident 28's Medication Administration Records (MAR), indicated the PRN lorazepam was administered as follows:- March 2025 - 19 times;- April 2025 - 14 times;- May 2025 - 4 times;- July 2025 - 3 times;- August 2025 - 13 times;- September 2025 - 26 times;- October 2025 - 41 times;- November 2025 - 34 times;- December 2025 - 21 times;- January 2026 - 9 times; and- February 2026 - 5 times (through February 13, 2026).A review of Resident 28's MAR from March 2025 to February 13, 2026, for PRN administration of lorazepam indicated ongoing use of lorazepam beyond 14 days.A review of Resident 28's Psychotropic IDT note - V 2, dated January 30, 2026, indicated a quarterly review of psychotropic medications, including PRN lorazepam. The form indicated the PRN lorazepam was marked as effective, and the frequency of PRN administration was documented as no change. The IDT recommended continuation of the current regimen. However, the record did not include physician-documented clinical rationale or a specified duration supporting continuation of PRN lorazepam beyond 14 days. No additional psychotropic IDT team notes were identified for the time periods reviewed during which PRN lorazepam orders extended beyond 14 days.On February 13, 2026, the facility provided a hospice Physician Order for Change in Plan of Care note signed and dated February 13, 2026. The document indicated it was a late entry for March 8, 2025, to May 27, 2025, for hospice order and included an order for PRN lorazepam. However, the documentation did not include physician-documented clinical rationale supporting continuation of PRN lorazepam beyond 14 days (continued on next page)

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	056214	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ramona Rehabilitation and Post Acute Care Center	485 W. Johnston Avenue Hemet, CA 92543

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during the time period reviewed. A review of Resident 28's Physician's Progress Notes, dated April 20, 2025, June 20, 2025, and July 30, 2025, did not indicate the physician documented a clinical rationale supporting continuation of PRN lorazepam beyond 14 days or specified duration of PRN lorazepam orders. Further review of Resident 28's record indicated there was no documented evidence the physician evaluated the use of PRN lorazepam beyond 14 days and there was no rationale for the continued use of the PRN lorazepam.On February 13, 2026, at 4:01 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON confirmed the hospice note did not include physician-documented clinical rationale supporting continuation of PRN lorazepam beyond 14 days. A review of the medical record with the DON, including progress notes and IDT psychotropic review notes for March through May 2025, and July 2025 through February 2026, did not identify physician-documented clinical rationale supporting continuation of PRN lorazepam beyond 14 days. The DON stated it was the facility's responsibility to clarify the duration and obtain physician-documented rationale when PRN psychotropic medications are continued beyond 14 days, even when the medication is ordered by a hospice physician. The DON further stated PRN psychotropic medications should be used judiciously due to potential adverse effects, including sedation and falls.A review of the facility's policies and procedures titled, Psychotropic PRN Medication Management, dated November 12 ,2025, indicated, .PRN psychotropic medications shall be prescribed and administered in accordance with applicable federal and state regulations. PRN orders will be reviewed periodically and managed consistent with regulatory requirements. When a PRN order reaches its designated duration of 14 days, the prescribing practitioner will determine whether continuation is clinically indicated. Documentation shall reflect clinical rationale, ongoing need when available, and monitoring consistent with resident condition. Renewal or discontinuation of PRN psychotropic medications shall be determined by the prescribing practitioner based on clinical judgment and resident status.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were administered and documented in accordance with the physician orders and the facility policy when the nursing staff administered an as-needed (PRN) medication but failed to document the administration in the Medication Administration Record (MAR), for one of six residents observed during medication administration (Resident 108).This failure resulted had the potential to compromise pain management, delayed evaluation of medication effectiveness, and increased the risk of duplicate dosing. Findings:On February 9, 2026, at 9:25 a.m., during a medication administration observation for Resident 108, Licensed Vocational Nurse (LVN) 3 was observed asking the resident if she was experiencing pain. Resident 108 stated she had no pain but felt uncomfortable in the abdominal area due to recent surgery. LVN 3 asked if Tylenol (brand name for acetaminophen, medication used to relieve pain and fever) would be acceptable, and the resident agreed.On February 9, 2026, at 9:31 a.m., LVN 3 asked Resident 108 her current pain level. Resident 108 stated her pain level was 3 (mild pain on a 0-10 pain scale, where 0 means no pain and 10 means severe pain). LVN 3 was observed administering nine prepared medications, including two tablets of acetaminophen 325 mg (milligram - unit of measurement) to Resident 108.On February 9, 2026, a review of Resident 108's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses, including small bowel obstruction (a blockage in the intestine), hernia status post exploratory laparotomy (hernia repaired through open abdominal surgery).A review of Resident 108's physician order, dated February 8, 2026, indicated:- Tylenol 325 mg (Acetaminophen), give two tablets by mouth every six hours as needed for mild pain.On February 9, 2026, at 11:57 a.m., a review of Resident 108's Medication Administration Record (MAR), dated February 2026, indicated there was no documentation for the 9 a.m. PRN acetaminophen dose administered. The MAR did not contain LVN 3's initials, time of administration, or documentation of medication effectiveness.A review of Resident 108's Care Plan Report, dated February 9, 2026, indicated the resident was at risk for abdominal pain related to recent surgery and required administration of analgesic medication as ordered. The care plan further indicated that staff were to evaluate and document the severity of pain and the resident's response to interventions.On February 9, 2026, 3:02 p.m., during a concurrent interview and record review of Resident 108's MAR with LVN 3, LVN 3 confirmed she had administered acetaminophen 325mg, two tablets, during the 9 a.m. medication pass but had not documented the administration in the electronic MAR. LVN 3 stated she forgot to select Yes in the MAR in PointClickCare (PCC, a cloud-based electronic health record and care coordination platform designed specifically for the long-term and post-acute care settings) to indicate the administration of acetaminophen. LVN 3 acknowledged approximately 5.5 hours had elapsed since the medication was administered and stated the documentation should occur after the medication was given.On February 11, 2026, at 10:44 a.m., during an interview with the Director of Nursing (DON), the DON stated medication administration must be documented in the MAR immediately after administration. The DON stated that without documentation, there is no record confirming the medication was given. The DON acknowledged the PRN acetaminophen was administered at 9:31 a.m. on February 9, 2026, was not documented in the MAR until approximately 5.5 hours later, at the time the omission was brought to the facility's attention and confirmed this was not in accordance with facility policy. The DON further stated documentation of PRN pain medication administration is essential to monitor the resident's pain status, evaluate effectiveness of treatment, and guide further clinical assessment.A review of the facility's policy and procedure titled, Preparation and General Guidelines, IIA2: Medication Administration - General Guidelines, dated February 2020, indicated, .Documentation (including electronic) .The individual who administers the medication dose records the administration on the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the individual who administered the mediation repot off-duty without first recording the administration of any medications.When PRN (as-needed) medications are administered, the following documentation is provided.a. Date and time of administration.c. Results achieved from giving the dose and the time results were noted. d. Signature or initials of person recording administration and signature or initials of person recording effects, if different from the person administering the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the consultant pharmacist's (CP) December 2025 Medication Regiment Review (MRR) recommendations were reviewed and acted upon in a timely manner, for two of five sampled residents (Residents 28 and 79).This failure had the potential to result in unresolved medication-related issues due to delayed evaluation of medication therapy and compromised resident care. Findings:1.On February 13, 2026, Resident 28's record was reviewed. Resident 28's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included Alzheimer's (memory loss).A review of Resident 28's physician orders indicated an active order for omeprazole (a medication used to reduce stomach acid, to treat frequent heartburn, acid reflux, and stomach ulcers) 20 mg (milligram - unit of measurement) delayed-release capsule (designed to release the medication in the intestine to prevent breakdown of the medication by stomach acids), one capsule by mouth daily for acid indigestion, dated December 13, 2025.A review of Resident 28's Consultant Pharmacist MRR, dated December 31, 2025, indicated a recommendation related to omeprazole. However, the recommendation was incomplete and partially unreadable, with missing or illegible portions, and the full content of the CP's recommendation could not be determined from the document provided.A review of Resident 28's Medication Administration Records (MAR), for December 2025, January 2026, and February 2026 indicated omeprazole was administered from December 14, 2025, through February 13, 2026.There was no documented evidence the facility sought clarification from the consultant pharmacist regarding the incomplete recommendation. There was also no documentation indicating the recommendation was endorsed to the physician or the physician reviewed and accepted or rejected the recommendation.On February 13, 2026, at 3:22 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON reprinted the original MRR document received via email from the CP and confirmed the recommendation remained incomplete, partially unreadable and missing contents. The DON stated she should have clarified the recommendation with consultant pharmacist and endorsed it to the physician for review. The DON acknowledged there was no documented evidence of physician review or action regarding the December 2025 MRR recommendation related to omeprazole. The DON stated physician review of CP's recommendations should occur within three to seven days. 2. On February 13, 2026, Resident 79's record was reviewed. Resident 79's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fracture of the vertebra (spine).A review of Resident 79's physician orders indicated omeprazole 20 mg, one tablet by mouth in the morning for gastrointestinal (GI - stomach and intestine) prophylaxis (used to prevent stomach irritation), dated November 7, 2025.A review of Resident 79's Consultant Pharmacist MRR, dated December 2025, indicated the CP recommended changing the administration time of omeprazole 20 mg from 9 a.m. to 6:30 a.m. to allow administration on an empty stomach prior to breakfast.A review of Resident 79's MAR for November 2025, December 2025, January 2026, and February 2026 indicated omeprazole remained scheduled at 9 a.m. and was administered at 9 a.m. from November 8, 2025, through February 13, 2026, except for December 20, 2025, when the dose was held.There was no documentation on the CP's MRR report, no physician progress notes, and no other medical record documentation indicating physician review, response or acceptance, or rejection of the CP's December 2025 recommendation.On February 13, 2026, at 2:39 p.m., during an interview and record review, the DON confirmed the December 2025 CP recommendation for Resident 79 was not reviewed by the physician in a timely manner. The DON acknowledged there was no documented physician review or action regarding the recommendation. The DON stated physician review of CP recommendations should occur within three to seven days. A review of the facility's Policy and Procedures titled, Consultant Pharmacist Reports, IIIA1: Medication Regimen Review, dated October (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2012, indicated, .The consultant pharmacist reviews the medication regimen of each resident at least monthly.Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's (active record) and reported to the Director of Nursing, and/or prescriber as appropriate.Recommendations are acted upon and documented by the facility staff and or the prescriber.Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing.A review of Micromedex (a clinical drug reference used by healthcare professionals), Omeprazole - Administration, dated January 28, 2026, Indicated, .Swallow capsule whole 30 minutes prior to the first meal of the day.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food served met the individual needs. for one of three residents (Resident 109), when the kitchen staff did not follow the diet spreadsheet during the tray line observation on February 11, 2026, for residents on renal diet (diet for patients with kidney disease by limiting potassium, phosphorus, and protein to reduce waste in the blood).This failure had the potential to compromise Resident 109's nutritional and health status.Findings:On February 11, 2026, at 11:55 a.m., tray line observation for lunch was conducted in the presence of the Dietary Supervisor (DS). The meal tray for Resident 109 was observed to contain one three-ounce of barbeque pork with one three-ounce piece of barbeque sauce, one piece of bread roll, one half-cup brussels sprout, and one half-cup of polenta, ready to be delivered. The DS was asked to check the meal tray prepared for Resident 109. The DS inspected the prepared meal tray for Resident 109 and stated the meal tray had barbeque sauce. The DS stated Resident 109 was on renal diet and should not have the barbeque sauce.On February 12, 2026, at 2:36 p.m., during an interview with the Registered Dietician (RD), she stated the kitchen staff should follow the spreadsheet when serving foods to the residents. She stated Resident 109 could not have the barbeque sauce in his diet. The RD stated the kitchen staff did not follow the spreadsheet for Resident 109 who was on renal diet.On February 11, 2026, Resident 109's record was reviewed. Resident 109 was admitted to the facility on [DATE], with diagnosis which included end stage renal disease (ESRD - final, irreversible stage of kidney failure requiring dialysis [a life sustaining treatment for kidney failure, filtering wastes and excess fluid from the blood when kidneys can no longer perform this function] or a transplant for survival) and diabetes (a chronic condition causing high blood sugar).A review of Resident 109's physician order dated February 4, 2026, indicated, .CCHO (Consistent or Controlled Carbohydrate - a meal plan for managing diabetes and blood sugar by consuming a similar, set amount of carbohydrates at each meal) Renal diet.Regular texture.Regular consistency.A review of the facility document titled, WINTER MENUS, for February 11, 2026, indicated, .RENAL DIETS.Pork.Gravy (no BBQ Sauce).