

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056346	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when: Several kitchenware stacked wet, and few kitchenware had oily substances and stored in the clean and ready-to-use areasTwo cooking pans were not well maintainedOne kitchen staff verbalized the process of the manual dishwashing with 3-compartment sink incorrectlyThe arrangement of the food stored in the walk-in refrigerator was not in a food safety mannerOne kitchen staff did not have hair restraint to cover the facial hairResidents' food in residents' food refrigerator found did not store and label properly These failures had the potential to cause food contamination which could cause illness to the medically vulnerable residents who consumed food from the kitchen and resident refrigerator in the facility. There were 117 out of 117 residents who consumed food from the kitchen.Findings:1. During an observation and concurrent interview with Dietary Aide (DA N), DA N on 1/6/26, at 9:45 a.m., was putting away dishes on racks and stated the racks were for dry and clean dishes and kitchenware should be completely dried before they are stored away. DA N stated she was responsible for checking the dishes and kitchenware to ensure they were clean and dry before stored on the racks. DA N confirmed the following items were stacked wet:-8 of 4-quart (fluid volume measurement) plastic containers-1 of 6-quart plastic container-1 of 12-1quart plastic container-1 of 3-gallon (fluid volume measurement) plastic container-5 plastic pitchers-5 plastic pitcher lids-3 plastic sippy cupsAn observation and concurrent interview with Certified Dietary Manager (CDM) was conducted on 1/6/26, at 10:10 a.m., observed there were issues found on the rack as followed:5 of full sheet metal pans (stacked wet; 3 of 5 had white substances on inside)8 of 1/6 sheet metal pans (stacked wet)11 of 1/3 sheet metal pans (stacked wet)2 of 1/2 sheet metal pans (stacked wet)CDM confirmed and stated the three pans were not clean and the substances looked like pan coating spray. CDM also stated all dishes, pot, and pans should be air-dried before stored away. CDM stated the wetness on the dishes would create problems.During an interview with Registered Dietitian (RD), on 1/8/26 at 3:01 p.m., RD stated the dishes and kitchenware should be air-dried before being stored away. She further stated they should be clean and checked before being stored away. RD stated the reason for air-dried was to prevent bacteria growth by the moisture.A review of facility policy and procedure (P&P) titled, Dishwashing, dated 2023, indicated, .Dishes are to be air dried in racks before stacking and storing.A review of facility P&P titled, Sanitation, dated 2023, indicated, .All utensil, counters, shelves, and equipment shall be kept clean.2. During an observation and concurrent interview with CDM on 1/6/26 at 10:11 a.m., two cooking pans (10 and 16) with coating found significant deep scratches on the coating cooking surfaces. In addition, both pans had brown substances on the cooking surfaces. CDM confirmed and stated she was aware of the scratches and they were old and should be discarded.A review of facility P&P titled, Sanitation, dated 2023, indicated, .All utensil. and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas.According to 2022 FDA (Food and Drug Administration) Food Code, on section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner and in an environment that promoted maintenance of quality of life for 9 out of 33 sampled residents (Resident 30, Resident 33, Resident 50, Resident 73, Resident 102, Resident 117, Resident 122, Resident 124, Resident 132) when:Staff spoke a non-English language in resident rooms during resident care when English was the residents' primary language.Resident 73 was not able to use eating utensils to eat his meal and had to use his hands. These practices had the potential for residents to not have their right for dignity, respect, and negatively impact on residents' physical, mental, and psychosocial wellbeing.Findings: During a review of facility policy titled, English Only Rule (undated) indicated, it was the facility's policy that staff only spoke English . in resident rooms . and in any area of the facility that a resident could hear staff speaking. The English Only Rule, indicated, a violation of this policy was a violation of resident rights and that when staff signed the document, they understood, speaking in a language the resident did not understand could cause fear, confusion, and disturb residents. During a review of the facility's policy titled, Resident Rights dated 12/1/21, indicated, Employees shall treat all residents with kindness, respect, and dignity. 1.During a review of the facility's record titled, Resident Council (an organized group of residents that met regularly to discuss and address concerns regarding their rights) meeting notes, dated 9/8/25 and 11/13/25, indicated, residents of the facility voiced concerns when facility staff did not speak English in their rooms, the hallways, and at the nurse's station. During a review of the facility's record titled, Resident Compliment or Concern document, dated 9/10/25, indicated the Director of Staff Development (DSD) provided education to facility staff regarding the facility policy for speaking English and the issue was resolved on 9/12/25. During a review of the facility's record titled, Resident Compliment or Concern document, dated 11/10/25, indicated the DSD provided education to facility staff regarding the facility policy for speaking English and the issue was resolved on 11/12/25. During a review of Resident 30's medical record indicated that Resident 30 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes (high blood sugar), obesity, and high blood pressure. During an interview on 1/6/26 at 9:08 am, Resident 30 stated that staff will come into his room and they will be talking in a language other than his own primary language and that he does not like it when they do that. Resident 30 states that this happens most often on the night shift. During a review of Resident 33's medical record indicated that Resident 33 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, stroke, and difficulty sleeping. During an interview on 1/6/26 at 11:10 am, Resident 33 stated that staff will come into his room and they will be speaking [NAME] to each other. He did not like this as it made him feel like the staff were talking about him. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 50's admission record, indicated that Resident 50 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, peripheral vascular disease (a circulation disorder where narrowed, blocked, or spasming blood vessels outside the heart and brain reduce blood flow to limbs and organs), and aortocoronary bypass graft (heart surgery that reroutes blood flow around blocked coronary arteries by grafting healthy blood vessels from another part of the body to create new pathways). During an interview on 1/6/26 at 8:45 am, Resident 50 confirmed that staff spoke [NAME] in her room during resident care. Resident 50 stated she did not like it. During a record review of Resident 102's admission record, indicated that Resident 102 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of bone (a cancerous tumor that starts in bone cells), cognitive communication deficit (difficulty with talking, listening, or understanding due to problems with thinking skills), and generalized muscle weakness. During an interview on 1/6/26 at 8:24 am, Resident 102 stated that the staff often spoke a Different language in her room and she did not like it. During a record review of Resident 117's admission record, indicated that Resident 117 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (the final stage of chronic kidney disease, where the kidneys lose almost all function), dialysis (a life-sustaining medical treatment that filters waste products and excess fluid from your blood when your kidneys can no longer do so), and hypokalemia (having abnormally low levels of potassium in your blood). During an interview on 1/6/26 at 8:41 am, Resident 117 stated [NAME] is being spoken on the floor and in our rooms. Resident 117 stated Administrator (Admin) was fully aware of this issue. Resident 117 stated she was frustrated because it made her feel like the staff spoke about her or one of her roommates. Resident 117 stated it made her feel isolated. Resident 117 stated she was the president of the resident council and this had been an issue discussed a lot of times during the monthly meetings. During a review of Resident 122's admission record, indicated that Resident 122 was admitted to the facility on [DATE] with diagnoses that included encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition), dementia (a progressive state of decline in mental abilities), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During an interview on 1/6/26 at 8:31 am, Resident 122 stated that the staff spoke another language in her room and she wished they would speak English, so she could understand if they were talking about her. During a review of Resident 124's admission record, indicated that Resident 124 was admitted to the facility on [DATE] with diagnoses that included fracture of right lower leg, pancytopenia (a lower-than-normal count of all three types of blood cells in the blood, resulting in increased infection risk, and bleeding issues), and cirrhosis of the liver (the liver becomes permanently scarred and damaged due to long-term injury). During an interview on 1/6/26 at 9:04 am, Resident 124 stated that staff spoke [NAME] in their room, and she had asked them to speak English many times. Resident 124 stated she would like to know if (continued on next page)		

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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. Based on observation, interview, and record review, the facility failed to ensure the medication administration error rate did not exceed 5% for 2 of 34 sampled residents (Resident 66 and Resident 89).1. For Resident 89, a licensed nurse administered canagliflozin (medication used to treat diabetes) not in accordance with Manufacturer's Specifications.2. For Resident 66, a license nurse administered two medications, spironolactone (used to help remove extra body fluid and swelling) and megace (a type of hormonal medication that increases appetite), not in accordance with Physician Orders, resulting in two sperate medication errors. As a result of this failure, 3 errors were identified of 25 opportunities during the observation of medication administration; the facility medication error rate was 12%. Findings: A review of facility policy titled Preparation and General Guidelines: Medication Administration, dated 8/2024, showed that Medications are administered as prescribed in accordance with good nursing principles and practices.1. During an observation of medication administration on 1/6/26 at 8:49 am, in Resident 89's room, Registered Nurse C (RN C) was observed to prepare and administer Resident 89's canagliflozin tablet medication by mouth. During an observation of Resident 89 on 1/6/26 at 8:49 am, in Resident 89's room, Resident 89 stated to RN C, Yes I've already eaten my breakfast, around 8 am. During an interview with RN C on 1/6/26 at 8:49 am, RN C confirmed that Resident 89 had already eaten breakfast, around 8 am that day. During a reconciliation of the observed medication administration with Resident 89's current physician orders indicated an order for Canagliflozin Oral Tablet 100 Milligrams (MG) Give 1 tablet by mouth one time a day for dm (Diabetes Mellitus). A review of Manufacturer's Specifications for Canagliflozin, indicated, The recommended starting dosage of Canagliflozin is 100 mg orally once daily to improve glycemic control, taken before the first meal of the day.During an interview with Director of Nursing (DON) on 1/9/26 at 9:58 am, the DON stated, I was not aware that Canagliflozin should be taken on an empty stomach. 2. During an observation of medication administration on 1/6/26 at 9:23 am, Licensed Vocational Nurse B (LVN B) was observed to administer Resident 66's medications. During this observation, LVN B was observed to not be wearing gloves during preparation, crushing, nor administration of potentially hazardous medications spironolactone and megace (Potentially hazardous medications are those that can alter your body's internal organs or hormones, and can be dangerous to handle without protective gear, especially when prepared or crushed, but are safe for the prescribed patient to take). During a reconciliation of the observed medication administration with Resident 66's current Physician Orders included the following orders:a) Oral tablet 25 milligram (mg) spironolactone (used to help remove extra body fluid and swelling), give 1 tablet by mouth two times a day for edema, use gloves when administering medication.b) megestrol acetate (a type of hormonal medication that increases appetite), suspension 400 mg/10 milliliter (ml). Give 10 ml by mouth one time a day, for appetite stimulant wear gloves when administering medication.During an interview with DON at 9:58 am, the DON stated Yes that nurse should have worn gloves for the spironolactone and megestrol, since they're hazardous.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the menu was followed for the therapeutic diet (a modification of a regular diet, tailored to fit the nutritional needs of a particular person - may be part of a treatment or medical condition and usually prescribed by a physician) during the lunch meals on 1/6/26 and 1/7/26 when: A. During a dining observation on 01/6/26: Resident 35 was on soft and bite size (sb) texture diets (all foods must be soft and able to mash with a fork and chopped into pieces no larger than 1.5 centimeters (cm) x 1.5 (cm) designed for residents who experience biting limitations but are able to chew food items for swallowing) received regular green salad instead of hot canned green beans. Resident 70 was on low fat and low cholesterol (lflc) diet (a diet designed to lower elevated levels of serum cholesterol and other lipids to reduce the risk of heart disease) received a cranberry crunch square instead of fresh fruit for dessert. Eight residents with sb and mince and moist (mm) texture diets (a diet soft, moist with excess fluid drained and minced to a size no larger than 4-millimeter x 15 millimeter designed for residents who experience biting, chewing, or swallowing limitations) did not receive hot canned green beans. B. During a meal service observation on 1/7/26: Seven residents with 2g (gram) Na (sodium) diet (restricted sodium 2-2.5 g/day in diet to manage heart disease, renal disease, and hypertension) diet received 1 whole serving of cake, crisp fish with tartar sauce, tator tots with ketchup, instead of 1/2 serving of cake, baked fish with lemon wedge and salt free french fries without ketchup. 24 residents with regular portions of CCHO (Consistent Carbohydrate) diet (a therapeutic diet to manage diabetic disease and/or to stabilize blood sugar level) diet should not receive dinner roll and margarine but they did. Resident 70 and Resident 114 with sb size texture diet received a whole regular dinner roll instead of soft and chopped rolls soaked in milk. Five residents with renal diet (diet used with renal insufficiency or with renal failure that are not on dialysis, a diet that regulates the dietary intake of sodium, potassium and protein to lighten the work of the diseased kidney) received oven crisp fish instead of baked fish. Four residents with lflc diet got tartar sauce for fish and margarine for roll instead of lemon wedge and no margarine. Eleven residents should have received dinner roll with their lunch meal did not receive them. Resident 17 and Resident 66 should have received a serving of cake with their meal who did not receive them. Resident 31 and Resident 117 with Renal 60g protein received three ounces (oz.) of fish instead of two oz. These deficient practices had the potential to result in compromising the medical and nutritional status of 57 residents for a census of 117 who consumed meals from the facility kitchen. Findings: A. During dining observation on 1/6/26, at 12:30 p.m. in the dining room, it was noted as followed: Resident 35 on sb diet received green salad and did not receive hot canned green beans. A concurrent review of the facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Winter menus, Week 2 Tuesday, indicated sb diet should receive hot canned green beans, not green salad. Resident 70, on the lflc diet, received a cranberry crunch square. A concurrent review of the facility spreadsheet titled, Winter menus, Week 2 Tuesday, indicated lflc diet should receive 1/2 cup fresh fruit, not cranberry crunch square. Eight residents with sb and mm diet did not receive them. A concurrent review of the facility spreadsheet titled, Winter menus, Week 2 Tuesday, indicated sb and mm diet should receive hot canned green beans. B. During the lunch meal distribution on 1/07/26, beginning at 12:11 p.m., it was noted as followed: Seven residents with 2g Na diet received one whole serving of cake, crisp fish with tartar sauce, tator tots with ketchup. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated 2g Na diet should have received 1/2 serving of cake, baked fish with lemon wedge, and [NAME] free french fries with no ketchup. 24 residents with regular portions of CCHO diet received dinner roll and margarine. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated CCHO diet should not receive dinner roll and margarine. Resident 70 and (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 114 with sb size texture diet received a whole regular dinner roll instead of soft and chopped rolls soaked in milk. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated sb diet should have received a wheat roll that was chopped, soaked and drained. Five residents with renal diet received oven crisp fish instead of baked fish. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated renal diet should receive baked fish and tartar sauce. Four residents with lfic diet got tartar sauce for fish and margarine for roll. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated lfic diet should have crisp fish with lemon wedge no margarine for the roll. Eleven residents should have received dinner roll with their lunch meal did not receive them. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated regular diets should have a wheat roll with margarine. Resident 17 and Resident 66 should have received a serving of cake with their meal who did not receive them. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated regular diets should have one serving apple hill cake. During an interview conducted with [NAME] 1 on 1/7/26, at 12:28 p.m., cook 1 confirmed and stated all crisp fish prepared were three oz. each. During meal distribution, noted Resident 31 and Resident 117 with Renal 60g protein received three oz. of fish instead of two oz. A concurrent review of facility spreadsheet titled, Winter menus, Week 2 Wednesday, indicated renal 60g protein should have two oz baked fish with tartar sauce. During an interview with Registered Dietitian (RD) and Certified Dietary Manager (CDM), on 1/7/26 at 2:20pm, RD and CDM acknowledged and confirmed the findings above. For the lunch meal during the dining observation on 1/6/26, RD reviewed the spreadsheet, she stated on 1/6/26 lunch meals, residents with sb and mm diet should get hot canned green beans. RD stated residents with sb texture diet should not get green salad but should get hot canned green beans. She acknowledged a resident with lfic diet who got cranberry crunch square, and concurrent review of spreadsheet, RD stated the resident should have received fresh fruit for dessert. RD and CDM acknowledged the findings of the meal distribution on 1/7/26, there were residents with 2g Na received 1 whole serving of cake, crisp fish with tartar sauce, tator tots with ketchup, concurrent review of the spreadsheet, RD confirmed they should have got 1/2 serving of cake, baked fish with lemon wedge and salt free French fries without ketchup. There were residents with regular portion of CCHO diet who received a dinner roll and margarine, concurrent review of the spreadsheet, RD confirmed they should not receive dinner roll and margarine. There were residents with sb texture diet that received regular dinner rolls, concurrent review of the spread, RD confirmed and stated they should have received chopped roll soaked in milk. There were residents with Renal diet that received oven crisp fish, concurrent review of spreadsheet, RD confirmed they should have received baked fish. There were residents with lfic diet that received tartar sauce for fish and margarine for the roll, concurrent review of the spreadsheet, RD confirmed and stated they should have received lemon wedge for fish and no margarine. There were residents who should have received a dinner roll with their lunch meal that did not receive a roll. RD stated, they should have the roll as the spreadsheet indicated. There were residents who should have received a serving of cake, but they did not. RD stated, they should have received cake as indicated on the spreadsheet. There were residents on Renal 60g protein diet that received 3 ounces of fish instead of 2 ounces of fish, concurrent review of the spreadsheet, RD confirmed and stated renal 60 g protein diet should have received two ounces of fish. During a follow up interview on 1/8/26 at 3:01 p.m., RD stated the dietary staff needed to follow the spreadsheet/menu, recipe and the meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) to follow the residents' preferences. RD stated she and CDM needed to provide in-service and would implement a tool to monitor the staff for following spreadsheet/menu. A review of the facility's policy and procedure titled, Menu Planning, dated 2023, indicated, 4. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines., Procedure 1. The facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility. 2. Menus are written for (continued on next page)		

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

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	regular and therapeutic diets in compliance with the diet manual.A review of the facility document titled, Job Description: Cook, revised July 2024, it indicated, .essential duties.inspect special diet trays to ensure the correct diet is served to the resident.review menus prior to preparation of food.prepare food in accordance with standardized recipe.planned menus and special diet orders.serve food in accordance with established portion control procedures		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility was failed to ensure the two dietary staff had proper skill to prepare the appropriate texture for Soft and Bite Size (SBS) texture (chopped or cut into pieces size no larger than 1.5 centimeter(cm) by 1.5cm) and Mince and Moist (MM) texture (soft and moist (with all excess fluid drained), size no larger than 4 millimeters (mm) by 15 mm), food items. This deficient practice had the potential to increase risk for the residents with swallowing and/or chewing difficulties to choke and/or aspirate (a condition in which food, liquids, saliva, or vomit is breathed into the airway). There were 31 residents on sb size texture diets and seven residents on mm texture diets, out of the census of 117. Findings: An observation of preparation of food items with SBS texture and MM texture and concurrent interview with [NAME] (CK) M was conducted on 01/7/26 at 10:30 a.m. CK M understood stated she had three food items: carrot, tater tots and crisp fish to make SBS, MM and puree textures. CK M stated she had to prepare 35 servings of SBS, 12 servings of MM, and four servings of puree for each food item. Observation of the SBS carrot preparation: CK M scooped the carrot into the food processor without measurement and blended the carrot. The final product looked like lumpy puree with chunks of carrot. CK M did not measure or test the texture of the processed carrot. Observed CK M did not review the recipe while making the SBS carrot. Observation of the MM carrot preparation: CK M prepared a pitcher of 16 ounces (oz) vegetable broth and added 16 pumps of liquid thickener to make thickened broth. CK M scooped an unmeasured amount of carrots into the food processor and added 1/4 cup of the thickened broth, then blended. The final product looked like puree and gluey. CK M did not measure or test the texture of the processed carrot. Observed CK M did not review the recipe while making MM carrots. Concurrent review of the bottle of liquid thickener, the instruction indicated eight oz. (1 cup) of fluid should add eight pumps of liquid thickener to make extremely thick or pudding thick consistency. Observation of pureed carrots preparation: CK M scooped an unmeasured amount of the carrots in the food processor, then she added unmeasured thickened vegetable broth, and blended. The blending time was longer than MM carrot. The texture was smoother without lumps. CK M did not test the texture of the pureed carrots and did not review the recipe while making the puree. Observation of the SBS tater tots preparation: Observed CK M scooped the tater tots into the food processor unmeasured and then blended. The final product looked like dry minced potato. CK M did not measure the size and test the final product. Observed CK M did not review the recipe while making the SBS tater tots. Observation of the MM tater tots preparation: CK M prepared 3/4 cup of milk and added 16 pumps liquid thickener in a measuring pitcher to make thickened milk. CK M scooped the tater tots into the food processor without measurement and added 3/4 cup of thickened milk and blended. The final product looked like puree with some lumps and sticky. CK M did not measure the size and test the final product. Observed CK M did not review the recipe while making the mm tater tots. Observation of the pureed tater tots preparation: CK M scooped the tater tots into the food processor without measurement. CK M added an unmeasured amount of milk into the food processor, then blended. The final product looked like mashed potato. Observed CK 1 did not review the recipe while making the pureed tator tots. Observation of the SBS crisp fish preparation: CK M counted 35 portions of crisp fish and added into the food processor and blended. CK M confirmed and stated each piece of the fish was three oz. The final product looked like dry minced fish. CK M did not measure the size and test the final product. Observed CK M did not review the recipe while SBS fish. Observation of the MM crisp fish preparation: CK M prepared one (eight oz.) cup of milk and added 16 pumps of liquid thickener to make thickened milk. CK M then put in 12 pieces of fish and add 1/2 cup of thickened milk in the food processor and blended the fish. The final product looked like coarse puree fish with lumps and was sticky when CK M scooped up the fish. Observed CK M did not measure the size or test the final product. CK M did not review the recipe while making the MM crisp fish. Observation of the pureed (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	crips fish preparation:CK M put four pieces of fish and added 1/2 cup of thickened milk in the food processor and blended. The blending time was longer than the MM fish. The final product looked smooth and pudding like fish. Observed CK M did not test the puree fish and did not review the recipe while making the pureed fish.During an interview with Registered Dietitian (RD) on 1/7/26 at 11:26 a.m., RD stated the facility started the transition from the old diet to IDDSI diet (The International Dysphagia Diet Standardization Initiative (IDDSI) is an international organization and it developed a standard that can be used to describe the characteristics of foods and drinks - from the point of view of a person with swallowing difficulties) on 12/1/25. Dietary staff had training of IDDSI with liquid thickener company representative. RD stated the representative came in once to do the training for all the dietary staff and Certified Dietary Manager (CDM). RD stated she attended as well. RD stated she had a brief in-service about IDDSI with the nurses and Certified Nurse Assistants (CNA)s. RD further stated the MM texture should not be sticky or gluey because those textures would be hard for the resident to swallow when they have problems with swallowing.RD stated CK M should measure and test after final products of each texture was done, A concurrent review of the recipes of carrot, tater tots and crisp fish, RD stated all the SBS texture should be chopped into the measurement of 1.5 cm by 1.5 cm in size and should perform testing to confirm the texture was correct. RD further stated all the MM texture food should be minced into the measurement of 4 millimeters (mm) by 15 mm by the food processor and moistened with gravy or sauce if needed. RD stated MM texture also needed to perform testing to confirm the texture was correct. For the puree texture, RD stated CK M should perform testing to confirm the texture is correct, RD confirmed and stated CK M did not prepare the SBS and MM texture correctly without measurement and confirmation testing and there was no confirmation testing for the puree texture.An observation and concurrent interview with Dietary Aide (DA) O on 1/7/26 at 11:39 a.m. was conducted. DA O stated she was prepping SBS dinner rolls, and observed DA O cut the rolls in half and added a small amount of milk in small bowl and let the rolls soak, then she drained the milk. DA O did not perform measurement and testing of the SBS rolls and did not review the instruction or recipe during the preparation.An observation and concurrent interview with DA O on 1/7/26 at 11:56 a.m. was conducted. DA O stated she was preparing MM dinner rolls and observed DA O put the rolls in the food processor and added an unmeasured amount of milk and then blended. DA O used a strainer to drain the milk. The final product was unable to measure and looked like oatmeal. DA O did not measure and test of the MM rolls and did not review the instruction or recipe during the preparation.An interview and concurrent recipes/diet manual (a written guide for healthcare facilities that provides guidelines for diets modified for consistency, specific nutrients, allergies, or medical conditions) review with RD was conducted on 1/7/26 at 12:02 p.m. RD stated the SBS dinner rolls should be chopped in the size of 1.5 cm by 1.5 cm and then soaked with milk and should not be cut in half. RD further stated the MM rolls should be chopped or processed to have a measurement of 4 mm by 15 mm in size and soaked in milk and then drained. RD agreed DA O did not make the SBS and MM rolls correctly and stated DA O needed to follow the instructions.A review of the IDDSI training report indicated CK M and DA O completed the training on 10/22/25 and 10/29/25 respectively. The training included using measurement and critical tests to confirm the appropriate textures for different food items as followed:For puree, the appearance indicated no lumps and passed the ford drip test (food sits in a mound above the dinner fork and does not drop or flow continuously through dinner fork) and spoon tilt test (food can hold shape on teaspoon and slides off spoon with little food left on the teaspoon).For MM texture, the appearance should be equal or less than 4 mm by 15 mm and passed the fork pressure test (food can be easily mashed with little pressure from a dinner fork) and the spoon tilt test.For SBS texture, the appearance should be equal or less than 1.5 cm by 1.5 cm and passed the fork/spoon pressure test (when pushing down on 1.5 cm by 1.5 cm food sample with a dinner fork or teaspoon, with enough pressure that the thumb nail turns white, the food can be squashed and will not return to original shape).A review of the departmental document titled, Recipe: Seasoned Carrots, dated 2025, (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated, .IDDSI #6/Soft & Bite Size: soft, chop into pieces = 1.5 cm by 1.5 cm in size.utilize the critical tests and IDDSI audit to confirm texture meets level #6 specifications.IDDSI #5/Mince & Moist: Mince before or after cooking. Measure desired # of servings into a food processor. Mince until food is in pieces = 4 mm by 15 mm. Moisten with gravy/sauce at appropriate thicken if needed.utilize the critical tests and IDDSI audit to confirm texture meets level #5 specifications.IDDSI #4/Puree: .Puree following the pureed recipe.Utilize the critical tests and IDDSI audit to confirm texture meets level #4 specifications.A review of the departmental document titled, Recipe: Hashbrowns or Fried Potatoes (same as tater tots), dated 2025, indicated, .IDDSI #6/Soft and Bite Size: Soft, no skin, chop into pieces = 1.5 cm by 1.5 cm in size. Be careful not to puree the potatoes.Utilize the critical tests and IDDSI audit to confirm texture meets level #6 specifications.IDDSI #5/Mince & Moist: Soft, no skin. Mince until the food is in pieces = 4 mm by 15 mm. Be careful not to puree the potatoes.IDDSI #4/Pureed: .Puree following the pureed recipes.utilize the critical tests and IDDSI audit to confirm texture meets level #4 specifications.A review of departmental document titled, Recipe: Oven Crisp Fish, dated 2025, indicated, .IDDSI #6/Soft & Bites Size: Tender, chop into pieces = 1.5 cm by 1.5 cm in size. Moisten with broth if needed.IDDSI #5/Mince & Moist: Tender, measure desired # of servings into the food processor. Mince until food is in pieces = 4 mm by 15 mm. Moisten with sauce at appropriate thickness if needed. Utilize the critical tests and IDDSI audit to confirm texture meets level #5 specifications.IDDSI #4/Pureed: . Puree following the puree recipes.utilize the critical test and IDDSI audit to confirm texture meets level #4 specifications.A review of Diet Manual, dated 2025, indicated grain (included baked goods) with IDDSI #5 Minced and Moist should be .without any added texture, moistened entirely through, that meet size specifications (no larger than 4 mm x 15 mm), with all excess fluid drained, must pass IDDSI #5 testing requirements (i.e. size, fork pressure, and spoon tilt tests) . It also indicated grain (included baked goods) with IDDSI #6 Soft and Bite size should be .without any added texture, moistened entirely through, that meet size specifications (no larger than 1.5 cm x 1.5 cm), with all excess fluid drained.must pass IDDSI #6 testing requirements (i.e. the fork test, for pressure tests) .A review of the facility document titled, Job Description: Cook/Kitchen Staff, revised July 2024, it indicated, .review menus prior to preparation of food.prepare food in accordance with standardized recipe.A review of facility document titled, Job Description: Registered Dietitian, revised July 2024, indicated, .Develop and evaluate regular and therapeutic diets including texture of foods and liquids to meet the specialized needs of residents.		

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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 that 1 of 34 sampled residents (Resident 8) were free of Unnecessary Medication, when Resident 8 had inaccurate diagnoses indications for receiving divalproex sodium, a psychotropic medication. This failure resulted in Resident 8 continuing to receive unnecessary psychotropic medications. Findings: A review of facility policy titled Medication Monitoring & Management, dated 8/2014, showed When a resident receives a new medication, the medication order is evaluated for the following . A written diagnosis, an indication, and/or documented objective findings support each medication. A review of Resident 8's medical records titled admission Summary, indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses included Unspecified Atrial Fibrillation (an irregular heartbeat), Metabolic Encephalopathy (confusion caused by illness), Chronic Obstructive Pulmonary Disease (a lung disease that causes breathing problems), Chronic Diastolic (Congestive) Heart Failure (weakly pumping heart that causes breathing problems), and Unspecified Psychosis (hearing or seeing things that are not real) not due to a substance or known physiological condition. A review of Resident 8's Minimum Data Set (MDS, an assessment tool), dated 8/22/25, indicated Resident 8 had multiple past episodes of psychosis and hallucinations. This record also indicated that Resident 8 had a Brief Interview for Mental Status (BIMS) score of 99 (unable to participate in interviews, and were severely cognitively altered.) During an interview with Registered Nurse K (RN K) on 1/8/26 at 1:46 pm, RN K stated they had taken care of Resident 8 many times in the last year, and knew them well. RN K stated that Resident 8 had previous episodes of psychosis and hallucinations, with behavioral outbursts. RN K stated that Resident 8 had no history of seizures. A review of Resident 8's medical record titled Order Summary, dated 1/8/26, indicated the following prescription: divalproex sodium (used to treat certain types of seizures) oral tablet extended release (ER) 24 hour 500 milligrams (MG), give 1 tablet by mouth one time a day for seizures, wear gloves when administering meds swallow whole do not crush/chew/open. The record indicated that Resident 8 began taking divalproex sodium on 9/30/25, and continued to, as of 1/8/26. During an interview with Director of Nursing (DON) on 1/9/26 at 9:58 am, the DON acknowledged that Resident 8 had an incorrect diagnosis of seizures documented as the indication for receiving divalproex sodium. During a concurrent interview and record review with Nurse Practitioner D (NP D) on 1/8/26 at 3:34 pm, NP D identified and confirmed the current medication orders for Resident 8 included Divalproex Sodium, and also confirmed the active diagnoses for Resident 8. NP D stated I see no seizure diagnosis for this Resident. NP D went on to say [Resident 8] has no history of seizures, that medication should have been for behavior. NP D also stated the order for Divalproex Sodium was entered incorrectly.		

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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 the necessary care related to activities of daily living (ADL) to maintain good personal hygiene when one of three sampled residents (Resident 26) fingernails were long, untrimmed, jagged, and had dirt and food under and on top of the nails. This failure had the potential for self-injury and infection due to unkept nails. Findings: During a review of the facility policy titled Fingernails/Toenails, Care of, dated 2/2018 indicated that nail care includes regular cleaning and trimming, trimmed nails prevent injury, and can aid in the prevention of skin problems. During a review of Resident 26's medical record indicated that Resident 26 was admitted to the facility on [DATE] with diagnoses that included muscle weakness, infection of the lower leg, and heart failure (the heart can't pump enough blood and oxygen to meet the body's needs). Resident 26's care plan dated 12/17/25 indicated that Resident 26 has an ADL self-care performance deficit related to weakness, poor endurance, and poor balance. During a review of facility Comprehensive Certified Nursing Assistant (CNA) Shower Review sheets for Resident 26, indicated that on 1/3/26 Resident 26 did not have his fingernails cut/cleaned. During an observation on 1/6/26 at 11:16 am, in Resident 26's room, Resident 26's nails were long, jagged, and dirty under the nails. During a concurrent observation and interview on 1/7/26 at 2:31 pm, in Resident 26's room, Resident 26 stated that he could not remember the last time staff cut his nails, but that staff could cut his nails and wash his hands any time they wanted. Resident 26 stated that he had two nails that were broken and jagged and needed to be cut. Resident 26's fingers were long, hand dirt and food on top and under them. During a concurrent observation and interview on 1/7/26 at 2:33 pm with CNA H, while in Resident 26's room CNA H confirmed that Resident 26's hands were dirty and had two nails that we broke and jagged. CNA H stated that they would have someone come in and clean Resident 26's hands and cut his nails. There was no documentation noting that any nail care had been done for Resident 26 on 1/7/26.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its enteral tube (delivers liquid food, medication, and fluids directly into the digestive system (stomach or intestines) when a person can't eat or swallow safely) medication administration policy when staff did not flush enteral feeding tubing with purified or distilled water as required. Instead, staff used tap water to flush the tubing. This deficient practice had the potential to introduce contaminants and place immunocompromised residents at risk for infection. Findings: During a review of the facility's policy and procedure titled, Enteral Tube Medication Administration, revised August 2014, it was indicated that warm purified, or sterile water is to be used for dissolving medications and flushing tube. During a review of Resident 2's medical record indicated Resident 2 was admitted to the facility on [DATE] with diagnosis including: cerebral infarction (stroke), dysphagia (difficulty swallowing), gastrostomy tube (a tube inserted through the wall of the abdomen directly into the stomach) for nutrition and hydration. A review of Resident 2's physician orders, indicated that it included flushing tube with 75 milliliters (ml) of water every 6 hours. During an observation on 1/8/2026 at 9:15 am in Resident 2's room, Registered Nurse (RN) L was observed using tap (sink) water to dissolve and flush medications through Resident 2's enteral feeding tube. During an interview with RN L on 1/10/26, at 10:00 am, RN L stated that she uses water from the sink for administering medications via an enteral tube as her standard of practice. Rn L stated that she has been following this method for the past 14 years and has not received any instruction on alternative procedures. During a concurrent interview and record review on 1/10/26, at 10:00 am, with the Director of Nursing (DON), the facility's policy and procedure titled, Enteral Tube Medication Administration, revised August 2014, was reviewed. The DON verified that the policy requires the use of warm purified, or sterile water for flushing enteral feeding tubes during medication administration. The DON acknowledged that the facility's current practice was to use tap water or water obtained from the kitchen for flushing enteral feeding tubes and stated the policy would need to be updated to reflect current facility practice.		

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NAME OF PROVIDER OR SUPPLIER Bridgeview Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 521 Lorel Way Yuba City, CA 95991	
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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the risk and benefits of bed rails (bed canes - safety device placed on the side of the bed used to help people with mobility issues move) for two of five sampled residents (Resident 10, Resident 14), when Resident 10 and 14 were using bed rails and did not have a bed safety assessment completed. This failure had the potential to put residents at risk for entrapment, accidents, and injuries. Findings: During a review of the facility policy titled Bed Safety and Bed Rails, dated 8/2022 indicated that bed rails come in different types, shapes and sizes and that the use of bed rails or side rails is prohibited unless the criteria for the use of bed rails has been met. The criteria includes attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The resident assessment determines the risk for entrapment, accidents and hazards, mobility restrictions, and psychosocial outcomes. During a review of Resident 10's medical record indicated that Resident 10 was admitted to the facility on [DATE] with diagnoses that included fracture of the left femur, type 2 diabetes (the body does not use insulin effectively or does not produce enough insulin causing sugar to build up in the blood), and muscle weakness. During a concurrent interview and record review on 1/8/26 at 1:44 pm, with the Director of Nursing (DON), the DON confirmed that Resident 10 had a physician order for bed canes dated 12/30/25 and Resident 10 did not have a bed safety assessment to ensure the safe use of the bed rails. During a review of Resident 14's medical record indicated that Resident 14 was admitted to the facility on [DATE] with diagnoses that included heart failure (the heart can't pump enough blood and oxygen to meet the body's needs), acute respiratory failure (a serious condition where the lungs can't pump enough oxygen into the blood), and muscle weakness. During a concurrent interview and record review on 1/8/26 at 2:05 pm with the DON, the DON confirmed that Resident 14 had a physician order for bed canes dated 10/25/25 and resident 14 did not have a bed safety assessment completed until 11/22/25 and it should have been completed when the bed canes were first installed.		

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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 observation, interview, and record review, the facility failed to ensure that their emergency drug kits (E-kit) had accurate or complete record keeping, when 1 of 4 antibiotic tablets was found to be unaccounted for. This failure had the potential for medications to be potentially lost or diverted without documentation. Findings: A review of facility policy titled Medication ordering and receiving from pharmacy: 1C5: Emergency Pharmacy Service and Emergency Kits, dated 8/2014, indicated, The nurse records the medication use from the emergency kit on the medication order/use form and Calls the pharmacy for replacement of the kit/dose and/or flags the kit with a color-coded lock to indicate need for replacement of kit/dose as soon as possible after the medication has been administered. During an inspection of the facility's medication storage room on 1/6/26 at 10:32 am, the emergency supply kit (a locked, specialized container or electronic cabinet that holds a small supply of critical medications, and allows staff to access and give medications without waiting for delivery) box # PO-27 was observed to be previously opened and accessed. The space for antibiotic sulfamethoxazole/trimethoprim tablet 800/160 MG (a combo of two meds, used to treat infections) was found to have 1 tablet inside, and receipts for two more tablets, which were taken out for resident use. This E-kit indicated that the box should contain 4 tablets, leaving 1 tablet unaccounted for. During an interview with Licensed Vocational Nurse (LVN) J on 1/6/26 at 10:32 am, LVN J stated, There has to be 4 pills, so one is missing. During an interview with Director of Nursing (DON) on 1/8/26 at 9:58 am, DON acknowledged the missing medication that the E-kit box was not accounted for.		

Department of Health & Human Services
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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 that Pharmacy staff were conducting accurate Medication Regimen Reviews for 1 of 34 sampled residents, when Resident 8 was found to have unnecessary medication prescribed for an incorrect diagnosis for 3 months. This failure had the potential to harm residents when medications were not monitored by pharmacy. Findings: A review of facility policy titled, Medication Monitoring & Management, dated 8/2014, indicated, When a resident receives a new medication, the medication order is evaluated for the following . A written diagnosis, an indication, and/or documented objective findings support each medication. This policy also showed The interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems (on an ongoing basis). A review of Resident 8's medical records titled admission Summary, indicated that Resident 8 was admitted to the facility on [DATE] with diagnoses included Unspecified Atrial Fibrillation (an irregular heartbeat), Metabolic Encephalopathy (confusion caused by illness), Chronic Obstructive Pulmonary Disease (a lung disease that causes breathing problems), Chronic Diastolic (Congestive) Heart Failure (weakly pumping heart that causes breathing problems), and Unspecified Psychosis (hearing or seeing things that are not real) not due to a substance or known physiological condition. This admission record did not list any diagnoses of seizures. During an interview with Registered Nurse K (RN K) on 1/8/26 at 1:46 pm, RN K stated they had taken care of Resident 8 many times in the last year, and knew them well. RN K stated Resident 8 did not have any history of seizures. RN K stated that Resident 8 had previous episodes of psychosis and hallucinations, with behavioral outbursts. A review of Resident 8's medical record titled Order Summary, dated 1/8/26, indicated the following prescription: divalproex sodium (used to treat certain types of seizures) oral tablet extended release (ER) 24 hour 500 milligrams (MG), give 1 tablet by mouth one time a day for seizures, wear gloves when administering meds swallow whole do not crush/chew/open. The record indicated that Resident 8 began taking divalproex sodium on 9/30/25, and continued to, as of 1/8/26. During an attempt to interview the facility's clinical pharmacist (CP), the facility was unable to arrange an interview with CP during survey hours. During a concurrent interview and record review with Nurse Practitioner D (NP D) on 1/8/26 at 3:34 pm, NP D identified and confirmed the current medication orders for Resident 8 included Divalproex Sodium, and also confirmed the active diagnoses for Resident 8. NP D stated I see no seizure diagnosis for this Resident. NP D went on to say [Resident 8] has no history of seizures, that medication should have been for behavior. NP D also stated the order for Divalproex Sodium was entered incorrectly.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that medications were stored at the correct temperatures. This failure had the potential for medications to not be therapeutically effective. Findings: A review of facility policy titled Medication Storage in the facility, dated 8/2014, showed Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. During an observation of Medication Storage room [ROOM NUMBER] on 1/6/26 at 10:32 am, two types of rectal suppository medications were found inside the refrigerator, which had a reading of 34 degrees Fahrenheit. These medications were found to be: 1) Acetaminophen (a medication used to treat fevers and mild to moderate pain) Suppository (a dissolving capsule inserted into the rectum, and releases medication), 650 milligrams (MG); packages for two residents found. A review of Manufacturer's Specifications for acetaminophen suppository, indicated Store at 20-25 degrees C (68-77 degrees F). 2) Hydrocortisone AC Suppository (used to treat swelling, redness, and itching in the rectum and lower intestines) 25 milligrams (MG); package for one resident found. A review of Manufacturer's Specifications for hydrocortisone rectal suppository, indicated Store at 20-25 degrees C (68-77 degrees F). 3) During an observation of Medication Storage Cart 1 on 1/6/26 at 11:15 am, one 120 milliliter (mL) amber colored bottle of liquid gabapentin was found in a drawer. This medication was being stored at room temperature (approximately 70 degrees Fahrenheit), in the facility hallway. A review of Manufacturer's Specifications for liquid oral gabapentin, indicated Storage & Handling: Store refrigerated, 2 C to 8 C (36 F to 46 F). During an interview with Licensed Vocational Nurse (LVN) H on 1/6/26 at 11:15 am, LVN H stated I think its ok after opening to store [liquid gabapentin] in the med cart. During an interview with Director of Nursing (DON) on 1/9/26 at 9:58 am, the DON stated, It's the responsibility of the pharmacy to label medications with temps and put away properly, but also nurses are responsible to check where meds should be stored.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and policy review, the facility failed to ensure two of seven sampled residents (Resident 13, and Resident 65) medical records contained accurate documentation when their Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) inaccurately indicated that Resident 13 and Resident 65 had advance directives (a written instruction, such as a living will or durable power of attorney for health care, recognized under State law, relating to the provision of health care when the individual is incapacitated [inability to make decisions]). These failures had the potential to result in delays or inaccuracies in Resident 13, and Resident 65's wishes being carried out if they were incapacitated. Findings: Review of a facility policy titled Advance Directives revised September 2022, indicated that Determining existence of advance directive 1. Prior to or upon admission of a resident, the social services director of designee (a person who has been officially chosen to do something) inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. And If a resident has an advance directive 1. Copies of these documents are obtained and maintained in the same section of the residents medical record and are readily retrievable by any staff. Review of Resident 13's health record indicated that he was admitted to the facility on [DATE] with diagnoses with included stroke, and high blood pressure. Review of Resident 13's POLST dated 8/5/25 indicated that he had an advance directive. During a review of Resident 13's health record no advance directive was present. Review of Resident 65's health record indicated that she was admitted to the facility on [DATE] with diagnoses which included dementia (loss of memory and ability to make sound decisions), and atrial fibrillation (an irregular and often very fast heartbeat that can cause poor blood flow). Review of Resident 65's POLST dated 10/15/24 indicated that she had an advance directive. During a review of Resident 65's health record no advance directive was present. During an interview on 1/7/26 at 2:50 p.m. interview with the Director of Nursing (DON), the DON indicated that there were no advance directives for Resident 13 or Resident 65. The DON indicated that she could not find them in the electronic health record but would ask medical records to see if they could find them. During a concurrent interview and record review on 1/8/26 at 9:10 a.m. with the Social Services Director (SSD), the SSD confirmed that the presence of an advance directive was checked off on Resident 13 and Resident 65's POLSTs and that there were no advance directives in Resident 13 or Resident 65's medical records. The SSD indicated that prior to three months ago nursing staff were determining if newly admitted residents had an advance directive but that she did not know what process nursing staff was using to determine if residents had advance directives. During an interview on 1/8/26 at 9:25 a.m. with the Medical Records Director (MRD), the MRD indicated that the existence of advance directives in Resident 13 and Resident 65's POLSTs were documentation errors, that neither Resident 13 or Resident 65 had an advance directive. And that nursing staff had been responsible for determining if there was an advance directive. When asked if there was any further documentation or process done regarding the determination that there was an advance directive, the MRD indicated that there was nothing further done by nursing staff except asking if there was an advance directive during the residents' admission to the facility.		