STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135077	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Transitional Care Center	1001 South Hilton Street Boise, ID 83705

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure residents were provided respiratory services consistent with professional standards of practice. This was true for 4 of 5 residents (#9, #23, #26, and #28) whose respiratory devices were not stored properly and 1 of 5 residents (#89) reviewed for physician orders for oxygen therapy. This deficient practice created the potential for residents to develop infection and to receive too little or too much oxygen. Findings include: 1. Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD is an ongoing lung condition that makes it difficult to breathe), chronic respiratory failure, and generalized muscle weakness. On 6/8/26 at 2:18 PM, Resident #9's nebulizer mask was observed laying on the bed. CNA #2 stated nebulizer masks should be stored in a plastic bag and it should not have been laying on the bed. On 6/10/26 at 8:53 AM, Resident #9's nebulizer mask was observed laying on the bed. LPN #4 stated the nebulizer mask should not have been laying on the bed and should have been stored in a plastic bag. LPN #4 replaced the mask and tubing and put it in a labeled bag for storage. 2. Resident #26 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including COPD, respiratory failure, and pulmonary embolism (PE- Occurs when a blood clot gets stuck in an artery in the lung, blocking blood flow to part of the lung). On 6/10/26 at 9:08 AM, Resident #26 was observed sitting on the right side of the bed. Her nasal cannula was observed on the right side of the bed on the floor and Resident #26 was observed stepping on the nasal cannula. On 6/10/26 at 9:26 AM, LPN #1 was asked about respiratory device storage. LPN #1 stated respiratory devices such as nasal cannulas should be stored in a bag. LPN #1 then accompanied the Surveyor to Resident #26's room and confirmed Resident #26's nasal cannula was on the floor at the bedside. LPN #1 stated Resident #26's nasal cannula should have been stored in a bag and replaced the oxygen tubing. 3. Resident #23 was readmitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure, pulmonary edema (fluid build up in the lungs), and need for assistance with personal care. A physician order dated 6/9/26 documented: -Oxygen at 2-5 liters via nasal cannula continuously. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/26 at 10:07 AM, NA #1 was observed pushing Resident #23 in his wheelchair. Upon entering the room, NA #1 removed Resident #23's nasal portable cannula and reached toward the bed to retrieve a nasal cannula lying directly on top of the resident's blankets. NA #1 then applied the cannula to Resident #23. On 6/11/26 at 10:13 AM, NA #1 confirmed the nasal cannula was not stored appropriately. NA #1 stated she applied the cannula but intended to obtain a new one afterward. 4. Resident #28 was admitted to the facility on [DATE] with multiple diagnoses including respiratory disorder, end stage renal disease, and need for assistance with personal care. Resident #28's physician orders documented the following: -Oxygen at 2 liters as needed for shortness of breath or respiratory distress, with physician notification (initiated 4/21/26). -Oxygen at 2 liters via nasal cannula continuously at bedtime (initiated 4/21/26). On 6/8/26 at 9:34 AM, Resident #28 was observed sitting in his wheelchair in his room. His nasal cannula was lying directly on his bed sheets. On 6/8/26 at 10:01 AM, LPN #3 stated nasal cannulas should be stored in a bag labeled with the date. LPN #3 confirmed Resident #28's cannula was not stored appropriately. 5. An NIH article, titled Bench-to-bedside review: Oxygen as a drug, Critical Care, dated Feb. 24, 2009, stated, 'Oxygen is one of the most widely used therapeutic agents. It is a drug in the true sense of the word, with specific biochemical and physiologic actions, a distinct range of effective doses, and well-defined adverse effects at high doses.' The facility's policy and procedure titled, Administration of Medication, revised 4/2025, stated, it is the policy of this Facility, medication shall be administered as prescribed by the resident's physician, nurse practitioner, or physician's assistant. Resident #89 was readmitted to the facility on [DATE] with multiple diagnoses including COPD, chronic respiratory failure (a long term condition where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide) and bronchiectasis (a chronic lung disease where the airways become permanently damaged, widened and scarred). Resident #89's physician's orders included the following: -oxygen at 2 liters via nasal cannula continuously, dated 6/1/26 On 6/8/26 at 2:50 PM, Resident #89 was observed in his room with the nasal cannula in his nares, oxygen set at 3.5 liters per minute. On 6/8/26 at 2:56 PM, LPN #3 checked Resident #89's orders and stated, oxygen should be set at 2 liters per minute. LPN #3 came into room and confirmed oxygen is set at 3.5 liters per minute and it should be at 2 liters per minute and corrected the flow rate.

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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 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, policy review, and staff interviews, it was determined the facility failed to ensure adherence to infection control and prevention practices, consistent with professional standards of practice. This was true for 3 of 3 residents (#6, #48, and #64) when staff did not follow hand hygiene protocols when going from a dirty to a clean environment during wound care and activities of daily living (ADL's), and 1 of 3 residents (Resident #6) observed for not following enhanced barrier precautions (EBP) during wound care. This deficient practice created the potential for harm to the residents due to cross-contamination and increased risk for infection. Findings include: Facility policy titled, Infection Control Prevention and Control Program-Hand Hygiene, reviewed 2/2025, documented, 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. -Before preparing or handling medications, before moving from a contaminated body site to a clean body site during resident care. -After contact with a resident's intact skin, after contact with bodily fluids. -After handling dressings, contaminated equipment (e.g. medical equipment) in the immediate vicinity of the resident. -After removing gloves. 1. Resident #48 was admitted to the facility on [DATE] with multiple diagnoses including dementia (a decline in mental ability severe enough to interfere with daily life), COPD, and muscle weakness. Resident #48's physician's orders included the following: -Venelex External Ointment, apply to affected area topically every day and night for skin integrity, dated 6/9/26. On 6/11/26 at 9:28 AM, LPN #2 was observed to perform hand hygiene, put on gloves and applied Venelex cream to buttocks bilaterally, she did not remove dirty gloves and handed Resident #48 the Biotene Mouth Moisturizer sitting on the bedside table. On 6/11/26 at 9:40 AM, LPN #2 stated, I should have removed gloves and washed my hands before handing her the Biotene. 2. Resident #64 was readmitted to the facility on [DATE] with multiple diagnoses, including muscle weakness, dementia, and need for assistance with personal care. On 6/11/26 at 12:28 PM, CNA #1 was observed providing incontinence care to Resident #64. CNA #1 was observed wearing gloves and unfastened Resident #64's incontinence brief and wiped her genital area. CNA #1 then threw away dirty wipes, and instructed Resident #64 to roll onto her left side. CNA #1 assisted Resident #64 to roll onto her side and then used wipes to clean Resident #64's bottom. CNA #1 then threw away the dirty wipes, removed the dirty incontinence brief and disposable chucks (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pad and placed it in the garbage next to Resident #64's bed. CNA #1 then grabbed a clean disposable chucks pad and clean incontinence brief from Resident #64's bedside table. CNA #1 then placed the new disposable chucks pad and incontinence brief under Resident #64 and assisted her to roll onto her right side and pulled the new chucks pad and incontinence brief out from under Resident #64. CNA #1 then assisted the resident to roll onto her back and fastened the new incontinence brief and pulled down Resident #64's shirt. CNA #1 then removed their gloves, performed hand hygiene at the sink, donned clean gloves, and covered Resident #64 with a clean sheet and blanket. CNA #1 was not observed to change their dirty gloves or perform hand hygiene before placing the new disposable chucks pad and incontinence brief. On 6/11/26 at 12:35 PM, when asked when gloves are changed, CNA #1 stated gloves are changed when dirty and further stated they should have changed their gloves after performing incontinence care. 3. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses including severe protein calorie malnutrition, major depressive disorder, anxiety disorder, and dementia. On 6/9/26 at 9:56 AM, RN #1 was observed entering Resident #6's room carrying woundˆcare supplies. RN #1 placed a barrier on the bedside table and set the supplies on the barrier. RN #1 then returned to the entryway, performed hand hygiene, and donned gloves followed by a gown. RN #1 approached Resident #6, adjusted the bed using the remote, and removed the resident's blankets. RN #1 and Unit Manager #1 repositioned Resident #6. RN #1 cleansed the wound with wound cleanser, patted the area dry, applied a contact layer and Ancef gel, placed a collagen pad over the wound bed, applied skin prep around the wound, and completed the dressing. During the procedure, RN #1 was not observed performing hand hygiene or donning and doffing gloves prior to initiating wound care, despite having touched the bed controls and resident linens. On 6/9/26 at 10:11 AM, Unit Manager #1 stated RN #1 should have applied the gown before donning gloves. Unit Manager #1 further stated that RN #1 should have performed hand hygiene after adjusting the bed and the resident's blankets, prior to beginning wound care.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were transferred to the hospital with all required documentation. This was true for 1 of 5 residents (Resident #64) whose hospital transfers were reviewed. This failure placed Residents #64 at risk for harm when the receiving healthcare institution were not provided the residents' care plan goals. The SOM, Appendix PP, revised 7/23/25 documented:When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider.(iii) Information provided to the receiving provider must include a minimum of the following:(A) Contact information of the practitioner responsible for the care of the resident.(B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with S483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. 1. Resident #64 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including muscle weakness, dementia, and left femur fracture.A review of Resident #64's medical record documented, she was admitted to the hospital on [DATE] after sustaining injuries from a ground level fall.A Progress Note dated 2/15/26 at 10:09 AM documented, Resident #64's Physician Orders for Scope of Treatment (POST- a medical order translating preferences for life-sustaining treatments into actionable instructions for healthcare providers), face sheet, and medication list were sent with the paramedics.Resident #64's medical record did not include documentation Resident #64's care plan goals were provided to the receiving healthcare institution.On 6/12/26 at 11:42 AM, when asked what documents were sent with residents when they transfer to the hospital, the DON stated bed hold agreements, face sheets, POST / advanced directive, history and physical, recent labs / imaging, medication list, 2 copies of electronic medication administration records (EMAR) were to be sent to the receiving healthcare institutions. She added, a call from the facility is made to the receiving healthcare institution to give a report. When asked what documents were sent when Resident #64 transferred to the hospital on 2/15/26, the DON stated the POST, Facesheet, & medication list were sent. When asked if Resident #64's care plan goals were sent, the DON and the CRN stated they did not see anything in the record documenting care plan goals were sent.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure the required Preadmission Screening and Resident Review (PASRR) process was completed accurately for a resident with mental health diagnoses. This was true for 1 of 2 residents (Resident #6) reviewed for PASRRs. This failure created the potential for the residents' mental health needs or need for specialized services to go undetected if PASRRs were inaccurate. Findings Include:Resident #6 was admitted to the facility on [DATE], with multiple diagnoses including a primary diagnosis of severe protein-calorie malnutrition, major depressive disorder, anxiety disorder, and dementia.Resident #6's PASRR level 1 dated 5/19/26, documented she had an anxiety disorder, mood disorder and a primary diagnosis of dementia.On 6/12/26 at 10:35 AM, the Social Services Manager confirmed Resident #6 did not have a primary diagnosis of dementia and stated she would complete a new PASRR level I.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure a comprehensive, personˆcentered care plan was developed to reflect the resident's diagnosed needs. This was true for 1 of 19 residents (Resident #27) reviewed for person-centered care plans. The failure to include Resident #27's PostˆTraumatic Stress Disorder (PTSD) diagnosis and related triggers in the care plan created the potential for unaddressed psychosocial needs and triggering of traumatic stress responses. Findings include:Resident #27 was admitted to the facility on [DATE] with multiple diagnoses including Post-Traumatic Stress Disorder (PTSD), schizoaffective disorder, major depressive disorder, and bipolar disorder.A Social Services Assessment/Evaluation, dated 5/27/26 documented in Section III, Question B (Experience of trauma or history of trauma?) the response documented was NO.A review of Resident #27's comprehensive personˆcentered care plan showed no care area addressing PTSD, despite the diagnosis being present in the medical record.On 6/12/26 at 10:33 AM, the Social Services Manager confirmed Resident #27's care plan did not address their diagnosis of PTSD or how to care for Resident #27's PTSD.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and staff interview, it was determined the facility failed to ensure necessary pressureˆrelieving boots were consistently applied as ordered to prevent development of pressure injuries and promote skin integrity. This was true for 1 of 5 residents (Resident #1) reviewed for pressure-injury prevention. This failure placed Resident #1 at increased risk for harm related to pressure-related skin breakdown. Findings includeThe facility's Skin and Wound Monitoring and Management Policy, revised 4/2025 documented:1. A resident who enters the facility without pressure injury does not develop pressure injury unless the individual's clinical condition or other factors demonstrate that a developed pressure injury was unavoidable; and 2. A resident having pressure injury(s) receives necessary and services to promote healing, prevent infection, and prevent new, avoidable pressure injuries from developing.Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses, including end stage renal disease, diabetes, and a pressure ulcer of the left heel.A review of Resident #1's care plan, revised 1/14/26, directed staff to apply Prevalon boots (a medical offloading devices designed to elevate the heel completely off the mattress to prevent pressure ulcers).A physician order dated 3/9/26 documented: [Prevalon] boots while in bed every shift for Skin integrity.On 6/10/26 at 2:17 PM and 3:33 PM, Resident #1 was observed sleeping in bed without Prevalon boots on. The Prevalon boots were noted on the floor at the end of Resident #1's bed.On 6/10/26 at 3:44 PM, LPN #1 was asked about the physician order for the Prevalon boots. LPN #1 confirmed Resident #1's Prevalon boots should be worn while in bed every shift for skin integrity per the physician's order. LPN #1 then accompanied the Surveyor to Resident #1's room and stated Resident #1 was not wearing the Prevalon boots and stated the resident should be wearing them while in bed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to follow up on the dialysis centers recommendations for a resident receiving dialysis services. This was true for 1 of 1 resident (Resident #28) reviewed for dialysis services. The failure to act on dialysis recommendations created the potential for adverse outcomes related to fluid management, a critical component of care for residents with end˜stage renal disease. Findings include:Resident #28 was admitted to the facility on [DATE] with multiple diagnoses including respiratory disorder, end-stage renal disease, and the need for assistance with personal care.A physician order dated 4/24/26 documented a 2,000 mL/day fluid restriction, broken down as follows:-Kitchen to provide 920 mL/day of drinks on tray-Nursing to provide 1,080 mL/[NAME] review of Resident #28's dialysis record dated 6/1/26, documented under Recommendations:Fluid restriction of 1 liter (1,000 ml/day.)On 6/11/26 at 2:37 PM, the DON stated, when the facility received recommendations, the facility will review and implement them. Upon review of Resident #28's record, the DON stated the dialysis center's recommendation was not processed by the facility.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure traumaˆinformed care services were provided in accordance with professional standards of practice and in a manner that accounted for the resident's experiences and preferences. This was true for 1 of 1 resident (Resident #27) reviewed for traumaˆinformed care. The facility's failure to identify and address traumaˆrelated needs created the potential for exposure to triggers and reˆtraumatization. Findings include:Resident #27 was admitted to the facility on [DATE] with multiple diagnoses including PTSD, schizoaffective disorder, major depressive disorder, and bipolar disorder.A review of Resident #27's comprehensive care plan did not document a focused care area addressing PTSD or triggers that may cause re-traumatization.A review of Resident #27's record showed no traumaˆinformed care evaluation, including:-No documentation of the resident's trauma history-No identification of trauma triggers-No documentation of preferences or refusals related to discussing traumaA review of the record also showed no documentation indicating that Resident #27:-Declined to discuss trauma history, or-Was offered the opportunity to discuss traumaˆrelated triggersOn 6/11/26 at 2:23 PM, the DON confirmed that Resident #27's record did not include a traumaˆinformed care evaluation.On 6/12/26 at 10:33 AM, the Social Services Manager stated she had evaluated the resident but did not complete a traumaˆinformed care evaluation. The Social Service Manager stated PTSDˆrelated triggers were not included because the resident did not wish to talk about it. She confirmed she did not document the resident's stated preference or refusal to discuss traumaˆrelated triggers in the medical record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were receiving medication with adequate monitoring. This was true for 3 of 6 residents (#19, #24, and #27) whose records were reviewed for unnecessary medications. This deficiency placed Residents #19 and #27 at risk for overmedication when their pain medication orders did not include parameters for administration and placed Resident #19, #24, and #27, at risk to suffer from side effects due to the lack of opioid side effect monitors. Findings include: 1. Resident #24 was admitted [DATE] with multiple diagnoses including diabetes (a condition that happens when blood sugars are too high), depression, and hypertension. Resident #24's physician's orders included the following: -Hydrocodone-Acetaminophen oral tablet 5-325 mg, give 1 tablet by mouth every 4 hours as needed for pain, dated 3/17/26. A review of the record showed no documentation of opioid side-effect monitoring such as: -Sedation -Dizziness -Nausea -Vomiting -Constipation On 6/12/26 at 12:59 PM, the DON confirmed Resident #26 did not have monitoring in place for adverse side effects related to opioid use and stated, they leave it up to the nurse to assess. 2. Resident #19 was admitted to the facility on [DATE] with multiple diagnoses including chronic pain syndrome and bladder cancer. Resident #19's medical record documented the following physician orders, dated 4/24/26 -Morphine Sulfate Oral Tablet 30 MG, Give 30 mg by mouth every 6 hours as needed for Pain -Oxycodone HCl Oral Tablet 5 MG, Give 10 mg by mouth every 4 hours as needed for Pain -Tylenol Tablet 325 MG, Give 2 tablet by mouth every 6 hours as needed for Pain Resident #19's medical record did not include documentation the facility was monitoring for side effects from the opioid pain medications prescribed. On 6/12/2026 at 9:54 AM, the DON stated Resident #19's pain medications orders should have been clarified to direct staff which medication to use for the reported level of pain. The DON stated Resident #19 did not have monitors in place to assess for opioid side effects. (continued on next page)

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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 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #27 was admitted to the facility on [DATE] with multiple diagnoses including PTSD, schizoaffective disorder, major depressive disorder, and bipolar disorder. a. Resident #27's record documented the following as needed (PRN) pain medications: -Acetaminophen 325 mg, 2 tablets by mouth every 6 hours as needed for pain (initiated 2/26/26). -Oxycodone 5 mg, 1 tablet by mouth every 6 hours as needed for pain (initiated 3/2/26). -HydrocodoneˆAcetaminophen 10ˆ325 mg, 1 tablet by mouth every 6 hours as needed for moderate to severe pain (initiated 4/20/26). A review of Resident #27's orders showed no instructions indicating: -Which PRN medication should be attempted first -Under what circumstances each medication should be used -Escalation steps for pain management On 6/11/26 at 2:25 PM, the DON confirmed the orders did not specify which medication should be given first. The DON stated the resident will request what she thinks she needs. B. Resident #27's record documented the following as needed pain medications: -Oxycodone 5 mg, 1 tablet by mouth every 6 hours as needed for pain (initiated 3/2/26). -HydrocodoneˆAcetaminophen 10ˆ325 mg, 1 tablet by mouth every 6 hours as needed for moderate to severe pain (initiated 4/20/26). A review of the record showed no documentation of opioid sideˆeffect monitoring. On 6/11/26 at 2:36 PM, the DON confirmed Resident #27 did not have monitoring in place for adverse side effects related to opioid use.