

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555158	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/09/2026
NAME OF PROVIDER OR SUPPLIER El Centro Post-Acute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 1700 S. Imperial Ave El Centro, CA 92243	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain and provide a safe, home-like environment when: 1. Resident rooms located on Station 1 were in need of repair for five of 20 rooms (Residents 54,118, 119, 122, and 137); and 2. Resident rooms located on Station 2 were in need of repair for four of 20 rooms (Residents 5, 20, 51, and 90). These failures had the potential for residents to feel undervalued and unappreciated. 2a. A review of Resident 20's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and cerebral infarction (an area of brain tissue death caused by a lack of blood flow and oxygen). On 1/6/26 at 8:19 A.M., an observation and interview was conducted with Resident 20 while inside the resident's room. The wall behind Resident 20's bed had been painted an olive-green color and had numerous areas of white colored streaks on it. On the wall across from Resident 20's bed, there was a power supply cable attached to a hanging cable box. A television monitor screen was hanging from the cable box. The television monitor and cable box had cords hanging down from it. Resident 20 stated the cable box had been like that for a long time. Resident 20 stated she felt like no one cared what her room looked like. 2b. A review of Resident 90's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis of Intervertebral disc disorder (the degeneration or breakdown of the spinal discs), muscle weakness and dementia. On 1/6/26 at 8:35 A.M., an observation was conducted in Resident 90's room. Resident 90 was not in her room. The wall behind Resident 90's headboard had been painted an olive-green color. The olive-green paint had been scraped down to the white drywall in various areas behind the headboard. The baseboard next to Resident 90's garbage can had been removed from the wall and drywall was exposed. On 1/6/26 at 8:52 A.M., an observation and interview was conducted with the Maintenance Director (MD) of Resident 20 and 90's rooms. The MD stated the power supply cables, cable boxes and wires had been hanging on the walls in many resident's rooms for a while and he was not sure when the cable boxes would be repaired. The MD stated when baseboards were removed from walls and drywall was exposed; he should have fixed it immediately. The MD stated he would not have exposed drywall at his home. The MD stated the rooms did not create a homelike environment. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2c. A review of Resident 5's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis of unspecified dementia (a progressive state of decline in mental abilities), muscle weakness and hemiplegia (a form of paralysis that causes weakness, loss of motor function, or complete paralysis on one side of the body). On 1/6/26 at 10:08 A.M., an observation was conducted of Resident 5's room. Resident 5 was not interviewable. The baseboard in Resident 5's room had been removed from the wall revealing white dry wall. On the wall across from Resident 5's bed were exposed cables hanging from a power supply cable box. An empty black cable box bracket was attached to the wall. Dry mounting tape and 4 drywall anchors were painted over next to the cable box. 2d. A review of Resident 51's admission Record indicated the resident was admitted to the facility on [DATE] with diagnosis of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), anxiety disorder and dementia. On 1/6/26 at 10:13 A.M., an observation was conducted in Resident 51's room. Resident 51 was not interviewable. The wall behind Resident 51's headboard had been painted an olive-green color. The olive-green paint had been scraped down to the white drywall in various areas behind the headboard. On 1/9/26 at 9:15 A.M., a joint interview was conducted with the Director of Nursing (DON) and the Administration (ADM). The DON and ADM stated they were aware the Resident rooms had baseboards pulled away with sheetrock exposed, cable television boxes hung with no televisions, wires displayed, walls with no paint and white sheet rock exposed. The ADM stated the resident rooms were not a homelike environment. The ADM stated that there had been a QAPI (Quality Assurance and Performance Improvement - a proactive approach combining QA and PI to improve resident care, safety, and quality of life) project identified for homelike environment. The DON stated that her expectation was that the resident rooms be clean and aesthetically pleasing and should be homelike for the residents. A review of the facility's policy titled Maintenance Service dated December 2009 indicated Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include but are not limited to .b. Maintaining the building in good repair and free from hazards.i. Providing routinely scheduled maintenance service to all areas.3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. Findings: 1a. Resident 118 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD-ineffective gas exchange within the lungs), per the facility's admission Record. According to Resident 118's admission Minimum Data Set (a clinical assessment tool), dated (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he was glad to be going home. 1d. Resident 137 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction (stroke), per the facility's admission Record. An admission MDS assessment had not yet been completed, due to the recent admission. An observation and interview was conducted with family visiting Resident 137, in her room on 1/7/26 at 1:50 P.M. Resident 137 was asleep in the bed and family were sitting in chairs next to the bed. On the wall next to the head of the bed, was wallpaper. The wallpaper was torn and peeling downwards. A visible uncovered phone socket was also on the wall near the head of the bed. The family members stated the room was not in good condition and did not present a homelike environment. 1e. Resident 54 was admitted to the facility on [DATE], with diagnoses which included dementia (progressive memory loss), per the facility's admission Record. According to Resident 54's quarterly MDS, dated [DATE], Resident 54 had a cognitive score of 5, indicating severe cognitive impairment. An observation was conducted of Resident 54's room on 1/7/26 at 12:15 P.M. The bed was empty and made. On the wall, near the head of the bed was multiple areas of peeling wallpaper. An observation and interview was conducted with certified nursing assistant (CNA 3) on 1/7/26 at 12:16 P.M. of Resident 112 and 54's room. CNA 3 stated if repairs were identified by staff, they were expected to put the repairs needed in the maintenance book, as a means of communication. CNA 3 observed the walls in Resident 137's and 54's room and stated, the walls do not look homelike, and if the resident were confused, they could peel off and ingest the wallpaper without realizing it could be harmful. An observation and interview was conducted with Licensed Nurse 2 (LN 2) on 1/7/26 at 12:23 P.M. of Resident 118, 119, and 122's room. LN 2 stated yes, the plastic bags and broken wood did not appear homelike and it looked tacky. An observation and interview was conducted with the Administrator (ADM) of the resident rooms on 1/7/26 at 12:30 P.M. The ADM stated yes, those were easy fixes and should have been corrected. The ADM stated they were in the process of re-doing resident rooms and had identified repairs were needed. An interview was conducted with the Director of Nursing (DON) on 1/8/26 at 11:41 A.M. The DON stated expected all the resident rooms to be in order and present as homelike. The DON stated she expected staff to identify repairs when needed and to document those repairs in the maintenance repair book. According to the facility's policy, titled Homelike Environment, dated 2021, .2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Theses characteristics include: a. clean, sanitary and orderly environment; .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, nonhazardous environment when:1. A bathroom for one of six residents (Resident 122), had a loose toilet seat, that was not tightened down and moved from side to side; and2. Hazards were identified in two of three resident shower rooms (Shower rooms [ROOM NUMBERS]). These failures had the potential for Resident 122 to become unbalanced and fall while using the bathroom and for residents using Station 1 and Station 2's shower room to cut, puncture, or injure themselves from the shower stall hazards.On 1/06/26 at 3:09 P.M., an observation and interview was conducted with Certified Nursing Assistant (CNA) 4 of shower room [ROOM NUMBER] (located by room [ROOM NUMBER]). CNA 4 stated there were orange-colored screws next to the handlebar that were protruding out from the tile, under the faucet, and next to the shower handlebar. CNA 4 stated she did not know why the screws were there. CNA 4 stated if a resident brushed up against a screw it could have caused a resident to get a skin tear, scrape, or be injured. On 1/6/26 at 3:34 P.M., an observation and interview was conducted with the Director of Nursing (DON) of shower room [ROOM NUMBER] (located by room [ROOM NUMBER]). The DON stated there were orange-colored screws sticking out from tiles, next to the handlebar, and under the water knob. The DON stated the white porcelain soap dish was broken and had jagged edges. The DON stated the screws and the broken soap dish were potential safety hazard because someone could have gotten cut or scrape their skin. The DON stated her expectation was that the soap dish and screws would have been removed immediately so no one would have been injured. On 1/6/26 at 3:48 P.M., a joint interview and observation was conducted with the Administrator (ADM) and Maintenance Director (MD) of shower room [ROOM NUMBER]. The MD stated he should have removed the protruding screws because someone could get hurt. The ADM stated they had been aware the showers needed to be worked on and that the screws needed to be removed and it should have been done. On 1/9/26 at 9:15 A.M., a joint interview was conducted with the Director of Nursing (DON) and the Administration (ADM). The DON and ADM stated they were aware that the showers needed repair and the dish soap was broken. The ADM stated there had been a QAPI (Quality Assurance Performance Improvement - a proactive approach to improving quality of care and resident safety) project identified to improve the environment. The DON stated her expectation was that the showers be safe for the residents' use. A review of the facility's policy titled Maintenance Service dated December 2009 indicated Policy Statement Maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to .b. Maintaining the building in good repair and free from hazards.i. Providing routinely scheduled maintenance service to all areas.3. The Maintenance Director is responsible for developing and maintaining a schedule of maintenance service (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 1. Resident 122 was admitted to the facility on [DATE] with diagnoses that included surgical aftercare following an intestinal obstruction (blockage), per the facility's admission Record. An interview was conducted with Resident 122 in his room, during initial tour on 1/6/26 at 8:36 A.M. Resident 122 stated his toilet seat had been loose since he arrived to the facility and he had asked numerous staff that it needed to be fixed. Resident 122 stated he was afraid he would fall every time he used the bathroom. An observation of Resident 122's bathroom was conducted on 1/6/26 at 8:37 A.M. The toilet seat moved from side to side when touch with my shoe and needed to be tightened down. A review of Station 1's maintenance book was conducted on 1/6/26 at 11:05 A.M. at the nursing station. There was no documented evidence in the maintenance book that Resident 122's toilet seat was identified as loose and a repair was requested. On 1/6/25, Resident 122's clinical record as reviewed. According to the Minimum Data Set (MDS - a clinical assessment tool), dated 12/30/25, Resident 122 had a cognitive score of 13, indicating cognition was intact. Resident 122's functional abilities assessment indicated he was independent and could ambulate on his own without any assistive devices. An observation and interview was conducted with certified nursing assistant (CNA 3) of Resident 122's toilet seat on 1/7/26 at 12:16 P.M. CNA 3 observed the loose toilet seat and stated someone could fall when trying to sit down or stand up. CNA 3 stated the toilet seat repair should be put in the maintenance book right away to avoid any injuries. A review of the maintenance book was conducted with CNA 3 on 1/7/26 12:21 P.M. CNA 3 stated the toilet seat for Resident 122 was not listed in the book, so she would log it in now and call the maintenance department. An observation and interview was conducted with Licensed Nurse 2 (LN 2) of Resident 122's bathroom on 1/7/26 at 12:23 P.M. LN 2 observed the loose toilet seat and stated, That's definitely a safety issue. An observation and interview of Resident 122's bathroom was conducted with the Administrator (ADM) on 1/7/26 at 12:30 P.M. The ADM observed the loose toilet seat and stated, That should have been reported and fixed. The ADM stated if Resident 122 told staff about the seat, she expected them to put the repair in the maintenance book so it could be fixed. An interview was conducted Director of Nursing (DON) on 1/8/26 at 11:41 A.M. The DON stated she expected staff to identify potential hazards and place the hazards in the maintenance book, so repairs could be made. According to the facility's policy, titled Falls and Fall Risk, Managing, dated 2001, .Fall Risk Factors: 1. Environmental factors that contribute to the risk of falls.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to follow professional standards for food service safety regarding storage when expired fish was found in a walk-in refrigerator. This failure had the potential to spread foodborne illness. On 1/6/26, at 8:30 A.M., a concurrent observation and interview was conducted with the Dietary Supervisor (DS) during an inspection of the walk-in refrigerator. A tray of fish covered with plastic was found labeled with an expiration date of 1/5/26. The DS stated this should have been discarded because it was expired. A facility policy titled Food Storage, dated 8/29/23, indicated that any expired or outdated food products should be discarded.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to implement and maintain infection control standards of practice when: Two of three shower rooms were found with black residue on the grout between the tiles. Resident 89's nebulizer tubing and mask were not discarded and changed weekly. These deficient practices had potential risks for residents and staff to contract infections. Findings: On 1/6/26 at 3:09 P.M., a joint observation and interview of shower room [ROOM NUMBER] (located by room [ROOM NUMBER]) was conducted with Licensed Nurse (LN) 3 and LN4. The shower stall had dark, scattered black residue in some of the grout and tiles on the wall and floor. In addition, there was dark, brownish, orange-colored streaks scattered on some of the tiles and next to the handrail. There was hair on the floor. LN3 stated the substance looked like mold and rust. LN3 stated the shower had not been cleaned between residents. LN4 stated the shower was not clean and it was important to be clean to prevent infection. On 1/6/26 at 3:18 P.M., an observation and interview of shower room [ROOM NUMBER] (located by room [ROOM NUMBER]) was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 stated the black residue between the tiles looked like mold and that the shower stall was not clean. CNA 4 stated this would not be considered clean at her house. CNA 4 stated it was important to be cleaned to prevent infection. CNA 4 stated each CNA was to clean the shower at the end of every shift. CNA 4 stated housekeeping was to deep clean the shower at the end of every shift. CNA 4 stated she was not sure if a CNA or a housekeeper had cleaned shower 1 between residents. CNA 4 stated there was not a log kept of shower cleaning. On 1/6/26 at 3:34 P.M., an observation and interview was conducted with the Director of Nursing (DON) of shower room [ROOM NUMBER] (located by room [ROOM NUMBER]). The shower stall had dark, scattered black residue in some of the grout and tiles on the wall and floor. In addition, there was dark, brownish, orange-colored streaks scattered on some of the tiles and next to the handrail. The DON stated the black colored substance could have been mold and the shower stall was not clean. The DON stated this could have been an infection control problem and it was important for the shower stall to be clean. On 1/6/26 at 3:48 P.M., a joint interview and observation was conducted with the Administrator (ADM) and Maintenance Director (MD) of shower room [ROOM NUMBER]. The MD stated the shower had looked like this for a very long time and did not look clean. The MD stated the black substance looked like mold and stated there was rust on the tiles. The ADM stated they had been aware that the showers had a dark black substance in the grout areas and rust on the tiles. The ADM stated the grout should have been white and should not have had black substance on it because it could have been mold and could have been an infection control issue. On 1/9/26 at 9:15 A.M., an interview was conducted with the ADM and the DON regarding shower rooms [ROOM NUMBERS]. The DON stated the shower stalls should have been wiped down with bleach wipes after each resident's shower for infection control purposes. The ADM and the DON stated shower stalls should be maintained in a cleanly manner at all times. The DON stated her (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation was that the dark, black mold should not have been present in the showers to prevent infection. A review of the facility's policy titled Cleaning and Disinfection of Environmental Surfaces revised August 2019 indicated, Policy Statement Environmental surfaces will be cleaned and disinfected according to current CDC recommendations for disinfection of healthcare facilities and the OSHA bloodborne pathogens standard.10. Environmental surfaces will be disinfected (or cleaned) on a regular basis. A review of the facility's policy titled Shower Policy revised February 2023, indicated .Post Shower .3. Clean and disinfect the shower area 2. Per the admission Record, Resident 89 was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness. On 1/7/26 at 9:40 A.M., a concurrent observation and interview was conducted with the Respiratory Therapist (RT) during a nebulizer breathing treatment (a small machine with a compressor, tubing, and medicine cup that creates the mist for breathing medicine). Resident 89's mask was observed labeled with a date of 12/28/25. The RT stated the mask should be changed weekly and that he did not notice the date on Resident 89's mask. The RT stated the mask should have been changed for infection prevention. On 1/9/26 at 9:25 A.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation and the facility policy that nebulizer tubing and mask were changed weekly for infection control. A review of the facility policy titled Respiratory Therapy - Prevention of Infection, dated 11/2001, indicated staff are to .discard the (nebulizer) administration set up every seven days .)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote dignity while assisting with a meal for one of three residents (Resident 70), by standing over the resident reviewed for Resident Rights. This failure had the potential for Resident 70 to feel overpowered, rushed, and undignified. Findings:Resident 70 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (a brain disorder), per the facility's admission Record.An observation was conducted inside Resident 70's room during lunch time on 1/6/26 at 12:38 P.M. A staff member was standing on the right side of the bed, feeding Resident 70 a pureed diet (a modified diet consisting of foods blended or mashed until they are smooth, moist, and pudding-like). The staff member was standing approximately 2 feet over the resident's head. An interview was conducted with the staff member, identified as certified nursing assistant 1 (CNA1), on 1/6/25 at 12:40 P.M., outside Resident 70's room. CNA 1 stated she thought it was alright to stand while feeding residents, that no one had ever told her otherwise. An interview was conducted with CNA 2 on 1/8/26 at 8:48 A.M. CNA 2 stated staff should always be at an eye to eye level while feeding residents. CNA 2 stated sitting eye-to-eye with a resident was important to identify early signs of choking, to show respect, and to encourage socialization.An interview was conducted with Licensed Nurse 1 (LN 1) on 1/8/26 at 8:53 A.M. LN 1 stated staff were expected to sit at an eye-to-eye level when feeding residents. LN 1 stated sitting with the resident during meals, demonstrated respect and encouraged the resident to take their time while eating. An interview was conducted with the Director of Nursing (DON) on 1/8/26 at 11:41 A.M. The DON stated she expected all staff to be at an eye-to-eye level when assisting residents with meals. The DON stated they could raise the bed up to maintain the eye to eye level, or sit next to the resident.According to the facility's policy, titled Assistance with Meals, dated 2017, .3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, example: a. Not standing over the residents while assisting them with meals.		

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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 interview and record review, the facility failed to implement a care plan related to monitoring an anticoagulant (blood thinner) for one of nine residents (Resident 42) reviewed for care plans. This had the potential to cause negative side effects and compromise Resident 42's health and safety. Findings: A review of Resident 42's admission Record, indicated the resident was admitted to the facility on [DATE] with diagnoses that included atherosclerotic (hardening of the arteries) heart disease. On 1/7/26 at 3:01 P.M., an interview and record review was conducted with Licensed Nurse (LN) 20. LN 20 reviewed Resident 42's care plan and physician's order. The physician's order indicated, Clopidogrel Bisulfate tablet 75 milligrams (mg) one tablet by mouth daily for Cerebrovascular Accident (CVA-stroke) prevention. The care plan titled Antiplatelet Care Plan indicated, risk for active bleeding, interventions to observe for signs and symptoms of abnormal bleeding such as bleeding gums, nosebleeds, black/tarry stools. LN 20 stated it was important to monitor and document negative side effects for patient safety. LN 20 stated the care plan should have been followed. On 1/8/26 at 2:55 P.M., a joint interview was conducted with the Director of Nursing (DON), and the Administrator (ADM), also present was the Nurse Consultant (NC). The DON stated licensed nurses should have monitored and documented negative side effects for residents on a blood thinner. The DON stated her expectations were for nursing staff to follow the care plans for residents. A review of the facility's policy titled Care Plan, revised November 2016, indicated .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.13. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to demonstrate a Nursing Standards of Practice during administration of medications via a gastrointestinal tube (G-Tube, a surgically inserted tube going into the stomach to provide nourishment, hydration, and medication when someone is unable to swallow safely on their own) for one of two residents (Resident 72) reviewed for G-Tube feeding. This failure had the potential for harm, when placement of the G-tube was not checked prior to medication administration, administering the crushed medications together, and using a syringe plunger to administer the medication instead of gravity, potentially causing too much pressure in the flexible tube, resulting in an implosion of the internal G-tube.(Cross reference F-759)Findings: Resident 72 was admitted to the facility on [DATE], with diagnoses which included hemiplegia following cerebral infarction affecting the right side (stroke with weakness on the right extremities) and dysphagia (difficulty swallowing), per the facility's admission Record. An observation of medication preparation and administration was conducted with Licensed Nurse 3 (LN 3) for Resident 72, on 1/7/26 at 10:12 A.M. LN 3 removed four separate medications and crushed them individually. The four medications included:Tamsulosin 0.4 milligrams (mg) (for enlarged prostate)Finasteride 5 mg (for enlarged prostate)Clopidogrel 75 mg (anticoagulant for thinning the blood)Cephalexin 500 mg (antibiotic for infection)LN 3 combined the four medications into one clear plastic medication cup and added 30 cubic centimeters (cc) of water for dilution. The mixture solution turned white. An observation of LN 3 administering the four diluted medications was conducted on 1/7/25 at 10:16 A.M. LN 3 did not check the G-Tube for proper placement before starting administration. LN 3 aspirated the diluted medication solution from the clear plastic cup with a large 60 cc syringe. LN 3 attempted to administer the medication via the syringe and had resistance when plunging. LN 4 obtained a new 60 cc syringe after 3 attempts with the old syringe, and the medication was administered using the syringe plunger to push the medication in. LN 3 withdrew 30 cc of water from a plastic cup with the syringe and used the plunger to push the water into the G-tube. An interview was conducted with LN 3 on 1/7/26 at 10:40 A.M., after completing medication administration. LN 3 stated she was taught in school to check for G-tube placement to make sure it was inserted into the stomach. LN 3 stated she should have checked Resident 72 for placement and she did not. LN 3 stated when she started at the facility three months ago, they did train and orient her on medication administration, but she did not receive any training for G-tube medication administration. An interview was conducted with LN 4 on 1/7/26 at 10:46 A.M. LN 4 stated it was important to always check G-tube placement before putting anything in the tube because the tube could have accidentally moved outside the stomach. LN 4 stated all crushed medication needed to be administered separately via G-tube to prevent any counter interactions or losing the effectiveness of each medication. LN 4 stated a syringe plunger should never be used to administer medication because the pressure used could rupture the tube. LN 4 stated medication and flushes should be administered by using gravity, for smooth, non-pressured administration. LN 4 stated all nurses needed to utilize the nursing standard of practice when administering medications via G-tube. Resident 72's clinical record was reviewed on 1/7/26 at 11 A.M. According to the physician's order dated 9/4/25: Check placement of G-tube before administering medication. Notify medical doctor if placement is not confirmed. In addition, dated 9/30/25, give Tamsulosin HCL oral capsule 0.4 mg. Open capsule to release contents. Mix with 10 cc of water, administer immediately to prevent beads from clumping. Also, dated 1/4/26, give cephalexin 500 mg, one tablet by mouth (not G-tube) every (continued on next page)		

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	four hours for cellulitis (infection in the soft tissue) to stoma (G-tube site). An interview was conducted with the Director of Staff Services (DSD) on 1/7/26 at 11:32 A.M. The DSD stated she trained all licensed nurses upon hire for medication administration. The DSD stated she had LNs first watch a video on medication administration and then she shadowed them during medication administration to ensure they had the skills and training to safely administer medication. The DSD stated her training and observation included administering medication via G-tube. The DSD stated she expected all staff to check placement of G-tube, administer the medications separately, and to use gravity flow. LN 3's employee file was reviewed on 1/7/26 at 10:40 A.M. According to the facility's New Hire Pharmacy Skills Checklist, dated 8/15/25, LN 3 was signed off as competent by the DSD for crushing medications. The skills check for Medication Administered via Feeding Tube, was listed as, Not Applicable and signed by the DSD. A follow up interview and record review was conducted with the DSD on 1/7/26 at 11:49 A.M., of LN 3 New Hire Pharmacy Skills Checklist. The DSD stated that was her signature on the Skills Checklist and she checked, Not Applicable on LN 3's skills list because she did not observe a G-tube medication administration and she now realized she should have. An interview was conducted with the Director of Nursing (DON) on 1/8/26 at 11:41 A.M. The DON stated Resident 72's medications were not administered properly, and they should have been. The DON stated she expected all nurses to follow the nursing standard of practice listed in their policy for G-tube medication administration. According to the facility's policy, titled Administering Medication through an Enteral Tube, dated 2001, . 6. Verify placement of feeding tube.10. Administer each medication separately.12. Administer medication by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion.13. If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount).		

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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 interview and record review, the facility failed to ensure adequate monitoring was provided for one of five sampled residents (Residents 42) receiving anticoagulant (blood thinner) medication. This had the potential to cause harm and compromise Resident 42's health and safety if signs and symptoms went undetected. Findings: A review of Resident 42's admission Record, indicated the resident was admitted to the facility on [DATE] with a diagnosis that included atherosclerotic (hardening of the arteries) heart disease. On 1/7/26 at 3:01 P.M., an interview and record review was conducted with Licensed Nurse (LN) 20. LN 20 reviewed Resident 42's physician's order. The Physician's order indicated, Clopidogrel Bisulfate tablet 75 milligrams (mg) one tablet by mouth daily for Cerebrovascular Accident (CVA-stroke) prevention. LN 20 stated there was no documentation for monitoring the negative side effects of the blood thinner for Resident 42 and there should have been. LN 20 stated it was important to monitor negative side effects for patient safety. On 1/8/26 at 2:20 P.M., a telephone interview was conducted with the Pharmacist (PH). The PH stated general side effects for Clopidogrel Bisulfate was abnormal bleeding, bruising, abdominal pain, bloody stools, nosebleeds. The PH stated monitoring for negative side effects should have been documented. The PH stated during the monthly medication review, the lack of documentation for negative side effects should have been identified. On 1/8/26 at 2:55 P.M., a joint interview was conducted with the Director of Nursing (DON), and the Administrator (ADM), also present was the Nurse Consultant (NC). The DON stated licensed nurses should have monitored and documented negative side effects for residents on a blood thinner. A review of the facility's policy titled Anticoagulant, revised November 2018, indicated .5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent during a random medication pass observation process for one of four residents (Resident 72). Resident 72 had four medications administered incorrectly. The facility's medication error rate was 13.79 percent. As a result, there was the potential for the four medications to become ineffective when crushed, combined, and administered together. (Cross Reference F-658 and F-842) Resident 72 was admitted to the facility on [DATE], with diagnoses which included hemiplegia following cerebral infarction affecting the right side (stroke with weakness on the right extremities) and dysphagia (difficulty swallowing), per the facility's admission Record. An observation of medication preparation and administration was conducted with Licensed Nurse (LN 3) for Resident 72 on 1/7/26 at 10:12 A.M. LN 3 removed four separate medications and crushed them individually. The four medications included: Tamsulosin 0.4 milligrams (mg) (for enlarged prostate) Finasteride 5 mg (for enlarged prostate) Clopidogrel 75 mg (anticoagulant for thinning the blood) Cephalexin 500 mg (antibiotic for infection) LN 3 was observed combining the four medications into one clear plastic medication cup and added 30 cubic centimeters (cc) of water for dilution. The mixture turned white. An observation of LN 3 administering the four diluted medications was conducted on 1/7/25 at 10:16 A.M. LN 3 aspirated the diluted medication solution from the clear plastic cup, with a large 60 cc syringe. LN 3 attempted to administer the medication via the syringe and had resistance. LN 4 obtained a new 60 cc syringe after 3 attempts with the old syringe, and the medication was administered using the syringe plunger to push the medication in. LN 3 withdrew 30 cc of water from a cup with the syringe and used the plunger to push the water in, flushing the G-tube (a surgically inserted tube going into the stomach to provide nourishment, hydration, and medication when someone is unable to swallow safely on their own). An interview was conducted with LN 3 on 1/7/26 at 10:40 A.M., after completing medication administration. LN 3 stated when she started at the facility three months ago, they did train and orient her on medication administration, but she did not receive any training for G-tube medication administration. LN 3 stated she was trained in nursing school to combine all the medications and then administer it. An interview was conducted with LN 4 on 1/7/26 at 10:46 A.M. LN 4 stated all crushed medication needed to be administered separately via G-tube to prevent any counter interactions, losing the effectiveness for each medication. Resident 72's clinical record was reviewed on 1/7/26 at 11 A.M. According to the physician's order dated 9/4/25, Check placement of G-tube before administering medication. Notify medical doctor if placement is not confirmed. In addition, dated 9/30/25, give Tamsulosin HCL oral capsule 0.4 mg. Open capsule to release contents. Mix with 10 cc of water, administer immediately to prevent beads from clumping. Also, dated 1/4/26, give cephalexin 500 mg, give one tablet by mouth (not G-tube) every four hours for cellulitis (infection in the soft tissue) to stoma (G-tube site). An interview was conducted with the Director of Staff Services (DSD) on 1/7/26 at 11:32 A.M. The DSD stated she trained all licensed nurses upon hire for medication administration. The DSD stated she had LNs first watch a video on medication administration and then she shadowed them during medication administration to ensure they had the skills and training to safely administer medication. The DSD stated her training and observation included administering medication via G-tube. The DSD stated she expected all staff to administer the medications separately. with flushes in between. LN 3's employee file was reviewed on 1/7/26 at 11:40 A.M. According to the facility's New Hire Pharmacy Skills Checklist, dated 8/15/25 was checked for competency. Technique for crushing medications was signed off by the (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DSD as competent The skills check for Medication Administered via Feeding Tube, was listed as, Not Applicable and signed by the DSD. A follow up interview and record review was conducted with the DSD on 1/7/26 at 11:49 A.M., of LN 3 New Hire Pharmacy Skills Checklist. The DSD stated that was her signature on the Skills Checklist and she checked, Not Applicable on LN 3's skills list, because she did not observe a G-tube medication administration and she now realized she should have. An interview was conducted with the Director of Nursing (DON) on 1/8/26 at 11:41 A.M. The DON stated Resident 72's medications were not administered properly, and they should have been. The DON stated she expected all nurses to follow the nursing standard of practice listed in their policy for G-tube medication administration. According to the facility's policy, titled Administering Medication through an Enteral Tube, dated 2001, . 10. Administer each medication separately.13. If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications. 14. When the last of the medication begins to drain from the tubing, flush the tubing with 15 ml of warm purified water (or prescribed amount).		

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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 interviews and record review, the facility failed to ensure a medication order was accurately documented for one of ten sampled residents (Resident 72) when a medication taken by mouth was ordered for a patient who receives medication via a gastronomy-tube (G-Tube - tube placed through the belly directly into the stomach to deliver liquid food, medicine, and fluids when someone can't eat enough by mouth). This failure had the potential for Resident 72 to be administered medications via the wrong route. Findings: Per the admission Record, Resident 72 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrotomy (opening made into the stomach) for g-tube. On 1/8/26 at 11:00 A.M., a record review of Resident 72's physician's orders was conducted. On 1/1/26 an order for Cephalexin 200mg tablet - 1 tablet four times a day by mouth for cellulitis (infection that makes the skin red, swollen, warm, and painful) to stoma (surgically created opening in the body) until 1/12/26 was placed and documented in Resident 72's clinical record. On 1/9/26 at 9:00 A.M., an interview was conducted with the administrator (ADM) and the director of nursing (DON). The DON stated Resident 72's medication order should have been documented as via GT and not by mouth. The DON stated it was her expectation that licensed nurses were to accurately document physician orders.		