STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess one of 18 sampled residents (Resident 12) for the ability to self-administer medications according to facility policy. This failure resulted in the potential for errors in Resident 12's medication administration. Findings: 1. During a review of Resident 12's Care Plan Report, the Care Plan Report indicated Resident 12 was admitted on [DATE] with diagnoses that include Type 1 Diabetes Mellitus (disease that causes increased blood sugar) and left eye blindness. During a concurrent observation and interview on 6/17/25 at 10:36 AM in Resident 12's room, 5 bottles of eye drops and 2 vials of insulin (medication to treat high blood sugar) was observed on the bedside table. Resident 12 explained that the nurse provided the medications at 6 AM for the resident to self-administer. Resident 12 stated she refilled her insulin pump (medical device that measures blood sugar and administers insulin) and self-administered her eye drops around 6:00 AM that morning before going to physical therapy. Resident 12 confirmed she had been self-administering her eyedrops and insulin since she was admitted to the facility. During a concurrent record review and interview on 6/19/25 at 2:10 PM with the Director of Nursing (DON), the DON stated she was unaware Resident 12 had been self- administering medications. DON stated, the Interdisciplinary Team (IDT) should have met to evaluate Resident 12's ability to self-administer medications and developed a plan of care. The DON confirmed that the IDT had not assessed the resident per policy to determine that it is safe for Resident 12 to self-administer their medications prior to the survey. During a record review on 6/18/25 at 8:05 AM of the facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated February 2021, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team (IDT) has determined that it is clinically appropriate and safe for the resident to do so. In addition, If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 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. Based on observation, interview, and record review, the facility failed to implement a comprehensive person centered care plan for one of 18 sampled residents (Residents 222) when Resident 222's care plan intervention to store cigarettes and lighter in a lock box was not implemented. This failure had the potential for unauthorized access by residents which could result in harm. Findings: During an observation on 6/17/25 at 9:00 AM, in Resident 222's room, the room door was open and Resident 222 was not in the room. One cigarette lighter was on the bed and another lighter was on the nightstand. A box of cigarettes was also placed on the nightstand. During a concurrent observation and interview on 6/19/25 at 8:47 AM, with Certified Nursing Assistant (CNA) 1, in Resident 222's room, the room door was open and Resident 222 was not in the room. Two packs of cigarettes were on the bed and box containing six cigarettes packs were on top of the nightstand. CNA 1 stated that the cigarettes should not have been left out unattended to prevent other residents from unauthorized access. CNA 1 stated the cigarettes should have been locked in the nightstand. During a concurrent interview and record review on 6/19/25 at 11:02 AM, with Licensed Vocational Nurse (LVN) 1, Resident 222' s Care Plan (CP) dated 5/29/25 was reviewed. The CP indicated, . [Resident 222] has potential for injury related to smoking . Will continue to demonstrate safe smoking . Cigarettes and lighter will be stored in [Resident 222] lock box in room . LVN 1 stated direct care staff should implement care plan. LVN 1 stated the cigarettes should have been locked in the nightstand so other residents cannot access it. During an interview on 6/19/25 at 11:18 AM, with the Director of Nursing (DON), the DON stated care planned interventions should have been implemented by all staff. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 03/2022, the P&P 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 .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observations, interviews and record reviews, the facility failed to ensure quality of care when physician orders to monitor fasting blood sugar levels of Resident 35, who is on insulin medication, were not followed and recorded. This deficient practice had the potential to adversely affect the resident's medical condition. Findings: During a review of the resident's record, the physician order dated 5/20/25 indicated, Check FSBG [Fasting Blood Glucose] QA.M [Every morning]. During an interview on 6/18/25 at 2:20 PM with Infection Preventionist (IP), IP stated there was an order for fasting blood glucose every day, but no fasting blood sugar values were recorded in the chart since 5/20/25. IP stated they are supposed to be monitoring the values per the Physician order. During an interview on 6/18/25 at 2:29 PM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 35's blood sugar should have been checked every morning. During an interview on 6/18/25 at 2:30 PM with Resident 35, Resident 35 stated that she was told by nurses she did not need her blood sugar monitored every day. During a review of the facility's policy and procedures (P&P) titled, Diabetes - Clinical Protocol Revised December 2015, the P&P indicated .monitor blood glucose levels twice a day if on insulin .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to provide pain management services consistent with professional standards of practice for two of 18 sampled residents (Resident 15 and 222) when: 1. Licensed Vocational Nurse (LVN) 1 administered pain medication one hour seven minutes after Resident 15 requested pain medication and did not conduct a pain reassessment within an hour after administration. 2. Licensed Nurses did not conduct pain reassessments within an hour after administering pain medication to Resident 222. This failure had the potential for Resident 15 and 222 to have unrelieved pain and diminished quality of life. Findings: 1.During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted Resident 15 on 5/22/2025, with multiple diagnoses including open wound to right foot, acute osteomyelitis (bone infection) right ankle and foot. During a review of Resident 15's Minimum Data Set, dated 5/27/25, indicated Resident 15's Brief Interview for Mental Status (BIMS) assessment score was 14. The BIMS assessment indicated Resident 15 was cognitively intact. During a concurrent observation and interview on 6/17/25 at 9:42 AM with Resident 15, Resident 15 pressed his call light. Certified Nursing Assistant (CNA) 2 responded to the call light, Resident 15 informed CNA 2 that he needed pain medication for his foot. Resident 15 stated he had pain in his right foot from exercising and this was his first time asking for pain medication since admission. During a review of Resident 15's Medication Orders (MO) dated 5/22/25, the MO indicated acetaminophen two tablets every 6 hours as needed for generalized discomfort. Monitor pain every shift 1-3 mild pain, 4-5 moderate pain, 6-9 severe pain and 10 excruciating pain. During an interview on 06/17/25 at 11:02 AM with CNA 2, CNA 2 stated she informed LVN 1 of Resident 15's request of pain medication soon after leaving his room. During a concurrent interview and record review on 6/17/25 at 11:26 AM with LVN 1, Resident 15's Medication Administration Record (MAR), dated 6/25 was reviewed. The MAR indicated, LVN 1 administered PRN (as needed) Acetaminophen 325 MG (milligram-unit of measure) for a pain level of 3 of 10 at 10:49 AM on 6/17/25 [one hour seven minutes later from Resident 15's request]. LVN 1 stated pain should be addressed within 15-20 minutes. During a concurrent interview and record review on 6/18/25 at 2:51 PM with Minimum Data Set Nurse (MDS), Resident 15's Medication Administration Note (MAN) dated 6/17/25 was reviewed. The MAN indicated LVN 1 reassessed Resident 15's pain level at 1:24 PM [two hours and 35 minutes later]. MDS stated Resident 15 had osteomyelitis (infection) to the right foot. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 222's AR, the AR indicated the facility admitted Resident 222 on 5/28/25 with multiple diagnoses including fracture of femur (thigh bone). During a record review on 6/19/25 at 11:05 AM, Resident 222's Medication Administration Record (MAR) dated 6/25 was reviewed. The MAR indicated, Resident 222 received PRN oxycodone (pain medication) for a pain level of 7 of 10 at 6:50 AM and was reassessed 10:14 AM [3 hours and 24 minutes later]. Resident 222 also received oxycodone at 7:08 PM for a pain level of 7 of 10 and was reassessed at 10:09 PM [3 hours later]. During an interview on 6/19/25 at 9:35 AM with the Administrator (ADM), ADM stated the facility did not have a policy in place to specify the timeframe the Licensed Nurse needed to reassess PRN oral pain medication. During an interview on 6/19/25 at 11:21 AM with the Director of Nursing (DON), the DON stated Licensed Nurses should respond to pain requests quickly to assess the underlying cause and intervene. The DON stated 30 minutes to an hour was a reasonable timeframe to reassess pain to ensure pain medication was effective. During a review of the policy and procedure titled, Answering the Call Light dated 10/2010, indicated, . Answer the resident's call as soon as possible .ask the nurse supervisor for assistance .If assistance is needed when you enter the room, summon help by using the call signal . During a review of the policy and procedure titled, Pain Assessment and Management dated 3/2015, indicated, .The pain management program is based on a facility-wide commitment to resident comfort .Pain management .includes the following .Monitoring for the effectiveness of interventions .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to provide nursing staff based on the 3.5 direct hours per patient day (DHPPD) for 27 out of 39 days reviewed. This failure resulted in two sampled residents, Resident 17 and Resident 37, ability to receive timely nursing care. This failure also had the potential to impact all residents in the facility. Findings: During a review of Resident 17's admission Record dated 6/18/25, the Admissions Record indicated that Resident 17 was admitted to the facility on [DATE] with the diagnosis of Cerebral Palsy (congenital disorder of movement, muscle tone, or posture), stroke (damage to brain from lack of blood supply), dementia (impairment of at least two brain function such as memory loss and judgement), and hemiplegia (muscle weakness of one side of the body). During a concurrent observation and interview on 6/17/25 at 9:30 AM with Resident 17 in his room, Resident 17 was observed laying on his right side, unable to reach his call light, and needed help to get up. Resident 17 had right hemiplegia and multiple contractures (unable to extend joints) to his elbow and hand. Resident 17 stated, It takes forever to get help here. I try to do as much as I can, but I need help. During a review of Resident 37's Minimum Data Set, dated 4/10/25, the Minimum Data Set indicated that Resident 37 was admitted to the facility on [DATE] with the diagnoses of Diabetes and Retinopathy (vision impairment). During a concurrent observation and interview on 6/17/25 at 12:40 PM, with Resident 37, in his room, Resident 37 was observed sitting on the side of his bed with the room dark (blinds pulled and lights off). Resident 37 indicated he was completely blind. Resident 37 stated, When I use the call light it takes a half hour, to an hour to get assistance. It is worse at night and on the weekends. Resident 37 stated, When I really need something, I go out to the nursing station and get it myself but I'm blind. Sometimes I call out until someone comes. During an interview on 6/19/25 at 8:30 AM with Certified Nursing Assistant (CNA) 3, CNA 3 stated, Often there is not enough staff. Today I have 15, I cannot care for the residents like I would like. During an interview on 6/19/25 at 8:45 AM with CNA 4, CNA 4 stated, Often there is not enough CNAs, I'm unable to spend as much time as needed to care for them, I feel rushed and cannot do a good job. During a review of California Department of Public Health workforce shortage waiver (staffing waiver), dated 6/14/24, the staffing waiver indicated, 2. The facility shall provide no less than 3.5 direct care service hours per patient day. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 6/19/25 at 9:00 AM with the Director of Nursing (DON), Census and Direct Care Service Hours Per Patient Day (DHPPD) dated 5/31/25 through 6/8/25 was reviewed. DON verified the DHPPD indicated eight of the nine days had a DHPPD of less than 3.5. DON stated that it is her expectation that call lights are to be answered within 15 minutes. During a review of DHPPD on 6/19/25, dated from 5/1/25 through 6/8/25, 27 of the 39 days reviewed indicated insufficient staffing levels of less than 3.5. The actual DHPPD hours are: 5/3/25 - 3.27 5/4/25 - 2.92 5/5/25 - 2.94 5/10/25 - 2.90 5/11/25 - 2.97 5/16/25 - 3.23 5/17/25 - 2.73 5/18/25 - 2.89 5/19/25 - 3.28 5/20/25 - 3.26 5/21/25 - 3.40 5/23/25 - 3.37 5/24/25 - 3.04 5/25/25 - 2.45 5/26/25 - 2.55 5/27/25 -3.38 5/28/25 - 3.27 5/29/25 - 3.47 5/30/25 - 3.29 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5/31/25 - 2.98 6/1/25- 2.57 6/2/25 - 3.23 6/3/25 - 3.33 6/5/25 - 3.47 6/6/25 - 3.26 6/7/25 - 2.78 6/8/25 - 1.96

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 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 had a medication error rate of 10 percent when three identified medication errors out of 30 opportunities were observed: 1. Aspirin 81 mg (miligram- unit of measurement) enteric coated (lower strength of aspirin that is often used to help prevent heart attacks and strokes) was administered without a physician's order for two residents (Resident 34 and Resident 54). 2. Lactulose (medication used to lower ammonia, a toxin in the body) was omitted without a physician's order for one resident (Resident 321). Findings: 1. During a review of Resident 34's Face Sheet (demographics), the Face Sheet indicated Resident 34 was admitted on [DATE] with diagnoses that included hypertension (high blood pressure). During a concurrent observation and interview on 6/18/25 at 8:13 AM with Licensed Vocational Nurse (LVN) 1 in Resident 34's room, LVN 1 administered one enteric coated (coated to resist stomach acid to dissolve in the intestines) tablet of Aspirin 81 mg (lower strength of aspirin that is used to help prevent heart attacks and strokes) to Resident 34. During a review of Resident 34's record on 6/18/25 at 9:10 AM, the Physician's Order dated 6/16/21 indicated, Aspirin Tablet Chewable (intended to be chewed for faster absorption) 81 mg, give once daily. During a concurrent observation and interview with LVN 1 at 9:48 AM, the medication label on the Aspirin bottle was reviewed with LVN 1 and compared against the physician order. LVN 1 confirmed the medication order for Resident 34 was for Aspirin 81 mg chewable tab. LVN 1 stated the enteric coated Aspirin she administered did not match the physician's order for Aspirin 81 mg chewable tablet. LVN 1 stated, there was no chewable Aspirin available in the medication cart. During an interview on 6/19/25 at 10:01 AM with Pharmacy Consultant (PC), PC stated that chewable aspirin and enteric-coated aspirin were not the same medication and should not be used interchangeably. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated that medications are administered in accordance with prescriber orders, including any required time frame. The P&P also indicated, The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 2. During a review of Resident 54's Face Sheet (demographics), the Face Sheet indicated Resident 54 was admitted on [DATE] with diagnoses that included hypertension (high blood pressure) and heart failure (condition where the heart muscle is unable to pump enough blood to meet the body's needs). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/18/25 at 8:19 AM with LVN 1 in Resident 54's room, LVN 1 administered one enteric coated (coated to resist stomach acid to dissolve in the intestines) tablet of Aspirin 81 mg (lower strength of aspirin that is used to help prevent heart attacks and strokes) to Resident 54. During a review of Resident 54's record on 6/18/25 at 9:15 AM, the Physician's Order dated 2/27/25 indicated, Aspirin Tablet Chewable (intended to be chewed for faster absorption) 81 mg, give once daily. During a concurrent observation and interview with LVN 1 at 9:48 AM, the medication label on the Aspirin bottle was reviewed with LVN 1 and compared against the physician order. LVN 1 confirmed the medication order for Resident 54 was for Aspirin 81 mg chewable tab. LVN 1 stated the enteric coated Aspirin she administered did not match the physician's order for Aspirin 81 mg chewable tablet. During an interview on 6/19/25 at 10:01 AM with Pharmacy Consultant (PC), PC stated that chewable aspirin and enteric-coated aspirin are not the same medication and should not be used interchangeably. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated that medications are administered in accordance with prescriber orders, including any required time frame. The P&P also indicated, The individual administering the medications checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 3. During a review of Resident 321's Face Sheet (demographics), the Face Sheet indicated Resident 321 was admitted on [DATE] with diagnoses that included hepatic encephalopathy (brain dysfunction that occurs when a damaged liver can't properly filter toxins from the blood). During a concurrent observation and interview on 6/18/25 at 8:30 AM with LVN 1 in Resident 321's room, LVN 1 prepared Resident 321's scheduled morning oral medications into a medication cup and administered the medications to Resident 321. LVN 1 did not administer Lactulose (a liquid medication) during the observation. During a review of Resident 321's record on 6/18/25 at 9:18 AM, the Physician's Order dated 5/31/25 indicated, Lactulose 45 ml (milliliters- unit of measurement), give four times daily. During an interview on 6/18/25 at 9:44 AM with LVN 1, LVN 1 confirmed she did not give the lactulose to Resident 321 during the medication pass. LVN 1 stated she forgot. During an interview on 6/19/25 at 10:01 AM with Pharmacy Consultant (PC), PC stated the significance of missing a dose of lactulose or not administering at the appropriate scheduled time was that the treatment would not work as intended. During an interview on 6/19/25 at 2:10 PM with the Director of Nursing (DON), the DON confirmed that nurses are expected to administer scheduled medications within an hour of the scheduled time of administration. DON further stated, if a dose was missed, the nurse is expected to contact the physician to determine if the medication should be given late or if the nurse should just wait until the next time of administration for the omitted medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, Medications administration times are determined by resident need and benefit . Factors that are considered include: a) enhancing optimal therapeutic effect of the medication; b) preventing potential medication or food interactions . Moreover, the P&P indicates, Medications are administered within one (1) hour of their prescribed time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. During a concurrent observation and interview on 6/19/25 at 1:40 PM, with Licensed Vocational Nurse (LVN) 1 at the medication cart. One box containing hemorrhoid ointment was observed with an expiration date of 4/25. LVN 1 stated the ointment was expired and should have been removed from the medication cart. During an interview on 6/19/25 at 2:17 PM, with the Director of Nursing (DON), DON stated medications should not be available for use past their expiration date because the effectiveness of the medication could not be ensured. The DON stated, staff should inspect the medication carts weekly and remove any expired medication. During a review of the facility's Policy and Procedure (P&P) titled Medication Labeling and Storage, reviewed February 2023, the P&P indicated, The nursing staff is responsible for maintaining medication storage and preparations areas in a clean, safe, and sanitary manner. If the facility has . outdated or deteriorated medications . pharmacy is contacted for instructions regarding returning or destroying these items. 3. During a review of Resident 271's Face Sheet the Face Sheet indicated Resident 271 was admitted to the facility on [DATE] with diagnoses which included Diabetes (disease causing high blood sugar levels). During a concurrent observation and interview on 6/19/25 at 1:40 PM, with Licensed Vocational Nurse (LVN) 1 at the medication cart, one opened multi-dose vial of insulin (medication used to control blood sugar) for Resident 271 was observed. The insulin vial was not labeled with the date it was opened. LVN 1 confirmed the insulin vial had been opened and used. LVN 1 stated insulin should be labeled with the date it was opened so that staff knew when it would expire. LVN 1 further stated insulin expired three months after it was opened. During an interview on 6/19/25 at 2:17 PM. with the Director of Nursing (DON), DON stated insulin should be labeled with the date it was opened and discarded 28 days after it was opened. DON stated, after 28 days, the insulin could lose potency. DON further stated, staff should label the insulin vial with the opened date so that they knew when it was time to discard it. During a review of the facility's Policy and Procedure (P&P) titled, Insulin Administration revised March 2025, the P&P indicated, Check expiration date, if drawing from an opened muli-dose vial. If opening a new vial, record an expiration date and time on the vial (follow manufacturer's recommendations for expiration after opening . During a review of the insulin manufacturer's instruction for use titled, Lantus Prescribing Information revised June 2023, the instructions indicated, Do not use after the expiration date stamped on the label or 28 days after you first open it. Based on observation, interview, and record review, the facility failed to safely store, and label drugs and supplies in accordance with acceptable standards of practice when: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Resident 222 had Fluticasone Propionate (nasal spray) on his bedside table. 2. Expired hemorrhoid cream was found in one of two medication carts. 3. Resident 271 was administered insulin from a previously opened but undated insulin vial. 4. Resident 12 had multiple eye drops and 2 vials of insulin on their bedside table. 5. 1 tab of Oxycodone HCl (oral pain medication) 5 mg (miligram- unit of measurement) was discarded into a non-controlled medication waste bin by Licensed Vocational Nurse (LVN) 1 without a witness. This failure had the potential to result in unauthorized access to medications and residents receiving expired medications which could lead to adverse effects. Findings: 1. During a review of Resident 222's admission Record (AR), the AR indicated the facility admitted Resident 15 on 5/28/2025, with multiple diagnoses that included respiratory disorder and Chronic Obstructive Pulmonary Disease (COPD-lung disease). During a concurrent observation and interview on 6/17/25 at 9:36 AM, with Resident 222, in Resident 222's room there was one Fluticasone Propionate located on top of Resident 222's bedside table. Resident 222 was alert and oriented. Resident 222 stated a staff member from the facility gave him the nasal spray. During a review of Resident 222 Order Summary Report (OSR) dated 5/28/25. The OSR indicated, Fluticasone inhale two times a day for COPD. During a concurrent interview and record review on 6/18/25 at 10:07 AM, with Licensed Vocational Nurse (LVN) 1, Resident 222's Physician Orders, dated June 2025, was reviewed. LVN 1 stated there was no Physician Order for bedside storage of Fluticasone Propionate. LVN 1 stated the nasal spray should not have been stored on the bedside cabinet without a physician's order. During an interview on 6/19/25 at 11:20 AM, with the Director of Nursing (DON) the DON stated medication should not have been stored in the room unless there was an order and care plan. The DON stated for safety, medications should be inaccessible to other residents. During a review of the facility's policy and procedure (P&P) titled, Bedside Medication Storage, dated 2007, the P&P indicated, .Bedside medication storage is permitted or residents who are able to self-administer medications, upon the written order of the prescriber .A written order for the bedside storage of medication is present in the resident's medical record . 4. During a review of Resident 12's care plan, the care plan indicated Resident 12 was admitted on [DATE] with diagnoses that included Type 1 Diabetes Mellitus (disease that causes increased blood sugar) and left eye blindness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/17/25 at 10:36 AM in Resident 12's room, 5 bottles of eye drops and 2 vials of insulin (medication to treat high blood sugar) were observed on the resident's bedside table. Resident 12 stated that the nurse provided the medications at 6 AM for the resident to self-administer. Resident 12 confirmed the medication had been sitting on her bedside table while she was in physical therapy. During an interview on 6/17/25 at 11:27 AM with Director of Nursing (DON) in Resident 12's room, DON confirmed that medications are not to be kept at the resident's bedside. The eye drops on the resident's bedside table observed by the DON were as follows: a. Atropine Sulfate Ophthalmic Solution 1% (Atropine Sulfate (Ophthalmic)- eye drops used to dilate (open) the pupil, relax the eye, and relieve eye pain from inflammation or swelling) b. Latanoprost Solution 0.005% (eye drops that help drain extra fluid from the eye to lower pressure) c. Simbrinza Opthalmic Suspension 1-0.2% (Brinzolamide-Brimonidine Tartrate- eye drop that lowers elevated pressure inside the eye) d. Timolol Maleate Gel Forming Solution 0.5% (eye drop that lowers pressure inside the eye by reducing fluid production) e. Prednisolone Acetate Ophthalmic Suspension 1% (steroid used to reduce inflammation or swelling in the eye) The two vials of Insulin Lispro (fast-acting insulin used to lower blood sugar in people with diabetes) on Resident 12's bedside table observed by the DON were as follows: a. Insulin Lispro 100 units per mL (unit of measurement) 10 mL bottle- sealed and unused b. Insulin Lispro 100 units per mL 10 mL bottle- vial empty. DON stated that medications should not be kept at the resident's bedside unsecured for the safety of the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated February 2023, the P&P indicated, Compartments (including, but not limited to, drawers, cabinets .and boxes) containing medications .are locked when not in use. During a follow-up interview on 6/19/25 at 2:10 PM with DON, DON stated the nurse should have observed Resident 12 self-administer their medications and taken the medications back from the resident. 5. During a concurrent observation and interview on 6/18/25 at 8:40 AM with LVN 1 outside Resident 321's room, LVN 1 accidentally dropped Resident 321's morning medications, including 1 tab of Oxycodone, a controlled medication (drug that is strictly regulated because it can be addictive or easily misused). LVN 1 discarded the 1 tab of Oxycodone into a locked medication waste bin without a witness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow up interview on 6/18/25 at 8:45 AM, LVN 1 stated that she should have obtained another licensed nurse to witness the disposal of the Oxycodone in the medication waste bin. During an interview on 6/18/25 at 1:45 PM. with the DON, the DON stated that if a nurse drops a controlled medication, it would be appropriate for the nurse to waste the controlled medication in the locked non-controlled medication waste container with a witness. She stated LVN 1 should have wasted the 1 tab of Oxycodone with another licensed nurse as a witness per policy. During an interview on 6/19/25 at 10:01 AM with Pharmacy Consultant (PC) via phone, PC explained that if a controlled medication was dropped during medication pass and must be discarded, the policy is for the nurse to waste with another nurse to ensure the medication was properly disposed of, inaccessible and not diverted. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances, dated November 2022, the P&P indicated, Waste and/or disposal of controlled medications are done in the presence of the nurse and a witness who also signs the disposition sheet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the kitchen food preparation and storage areas were maintained in a safe and sanitary manner when two fans blowing air into the kitchen had fine white colored particles. This failure placed all residents who received food prepared in the kitchen, at risk for foodborne illness and food contamination. Findings: During a concurrent observation and interview on 6/18/25 at 11:35 AM, with the Registered Dietitian (RD), in the kitchen, a stand-up fan had fine white colored particles and was blowing air directed into the food delivery cart. A floor fan had fine white colored particles and was blowing air directed to the tray-line and food preparation area. RD stated it was dust on both fans and stated that the fans should be dust free because the dust particles can land on the food. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces, the FDA Food Code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. During a review of the facility's policy and procedure (P&P) titled, Sanitization dated 11/2022, the P&P indicated, .The food service area is maintained in a clean and sanitary manner .All kitchens, kitchen area and dining areas are kept clean, free from garbage and debris .All equipment .are clean and sanitized .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555222	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeport Post Acute	1291 Craig Avenue Lakeport, CA 95453

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when powder like substance was observed on the surface areas around two of two pill crushers. This failure had the potential to result in harm from cross contamination. Findings: a. During a concurrent observation and interview on 6/19/25 at 1:28 PM, with Licensed Vocational Nurse (LVN) 2 in the facility hallway, the pill crusher on the medication cart for side two of the facility was coated in white and black colored powder-like substance. LVN 2 stated the pill crusher was dirty and that it should have been cleaned to prevent cross contamination. b. During a concurrent observation and interview on 6/19/25 at 1:40 PM with LVN 1 in the facility hallway, the pill crusher on the medication cart for side one of the facility was coated in white, brown, and black colored powder-like substance. LVN 1 stated the pill crusher was dirty. During an interview on 6/19/25 at 1:47 PM with the Director of Nursing (DON), the DON stated the pill crusher should have been cleaned after each use. The DON stated any residual should be cleaned with bleach wipes before crushing another medication. During a review of the Instruction for Using (IFU) [Brand Name] pill crusher titled Cleaning and Maintenance Instructions undated was reviewed. The IFU indicated, .May be cleaned regularly with a damp cloth .Using a damp cloth, wipe clean the [Brand Name] Pill Crusher using a normal detergent and water. Wipe down with dry cloth .