STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555309	A. Building B. Wing	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 ensure an assessment for safe self-administration of medication was conducted for two of three residents reviewed for choices (Residents 2 and 146). These failures had the potential for Residents 2 and 146 to self-administer the medications unsafely and without licensed nurse monitoring.Findings: 1.On September 22, 2025, at 11:35 a.m., a concurrent observation and interview were conducted with Resident 146. Resident 146 was observed lying on her bed, alert and oriented. An opened bottle of a 16oz (ounce) 3% hydrogen peroxide (an antiseptic [kills germs] solution used for disinfecting minor cuts and scrapes on skin and used as a gargle or rinse to help remove mucus and phlegm from the mouth and throat) was observed on the bedside table. Resident 146 stated her daughter bought the medication from a drug store and brought it to the facility to help her rinse her mouth after she ate. Resident 146 stated she had used the medication that morning after breakfast and had kept it at her bedside for few days. Resident 146 stated none of the staff asked her about it. On September 22, 2025, at 11:40 a.m., a concurrent observation and interview were conducted with Licensed Vocational Nurse (LVN) 1 inside Resident 146's room. LVN 1 stated she had provided care for Resident 146 but was not aware of any medication at the bedside. LVN 1 stated residents would need a self-administration assessment. LVN 1 stated she was unsure if Resident 146 had been evaluated. A review of Resident 146's records indicated Resident 146 was admitted to the facility on [DATE], with diagnoses including shortness of breath and nicotine dependence (a condition in which a person becomes physically and psychologically addicted to nicotine [substance found in tobacco products such as cigarettes]). A review of Resident 146's Minimum Data Set (MDS - an assessment tool) dated September 23, 2025, indicated a Brief Interview of Mental Status (a tool to assess cognitive function of an individual) score of 14 (cognitively intact). A review of Resident 138's History and Physical, dated September 18, 2025, indicated Resident 146 had the capacity to make decisions. Further review of Resident 146's records indicated there was no documentation Resident 146 had been assessed for medication self-administration. On September 22, 2025, at 3:34 p.m., a concurrent interview and record review of Resident 146's records were conducted with LVN 2. LVN 2 stated there was no documented evidence in Resident 146's records that she was assessed to self-administer any medications. LVN 2 stated, residents would need to be assessed to determine if they were capable of self-administering medications and for residents' safety. 2. On September 22, 2025, at 3:05 p.m., a concurrent observation and interview were conducted with Resident 2. Resident 2 was observed sitting on his bed watching television, alert and oriented. The following multiple over the counter (OTC - medicines which can be purchased without a prescription) medications were observed at his bedside:a. 16oz bottle of hydrogen peroxide topical solution (open)b. 1oz triple antibiotic ointment tube (topical first-aid medication containing three different antibacterial agents to treat minor skin irritations) (open)c. 3oz Medline Remedy Antifungal Powder (prevent fungal growth) (open)d. 10oz Gold Bond Medicated Body Powder (absorb moisture, control odor, and relieve itchiness) (open)Resident 2 stated he ordered the medications three weeks ago. Resident 2 stated he last used the antibiotic ointment 2 weeks ago for a pimple on his right cheek and have kept the medications on top of his drawer and no (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	one had asked about them. On September 22, 2025, at 3:14 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 3. CNA 3 stated she has provided care for Resident 2 and have not noticed any medications in Resident 2's room. CNA 3 stated licensed nurses were supposed to check if they were safe to have medications at the bedside. On September 22, 2025, at 3:23 p.m., a concurrent observation and interview was conducted with LVN 2 in Resident 2's room. LVN 2 stated she was not aware that Resident 2 had been ordering medications and storing them in his room. LVN 2 stated residents were not allowed to keep medications at the bedside without a self-administration assessment. A review of Resident 2's records were conducted. Resident 2 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (abnormal heart rhythm) and low back pain. A review of Resident 2's MDS, dated [DATE], indicated a BIMS score of 15 (cognitively intact). Further review of Resident 2's records indicated there was no documentation that Resident 2 was assessed for medication self-administration. On September 22, 2025, at 3:30 p.m., a concurrent interview and record review of Resident 2's records were conducted with LVN 2. LVN 2 stated there was no documented evidence in Resident 2's records that he was assessed to self-administer the OTC medications. LVN 2 stated, without an assessment, Resident 2 should not have any medications at the bedside, as the staff would be unable to monitor whether the resident was using the medication safely. On September 25, 2025, at 2:04 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated without a self-administration assessment, Residents 2 and 146 should not have any medications at the bedside. The DON stated her expectations was for staff to inspect resident's rooms for medications at bedside and report right away. The DON stated both Residents 2 and 146 did not have self-administration assessments completed and further stated, they should have been evaluated to ensure they were using the OTC medications safely and the residents were being monitored. A review of facility's policy and procedure titled Self -Administration of Medications, dated 2001, indicated, .Residents have the right to self-administer medications if the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the residents.the resident is able to safely and securely store the medications.this is documented in the medical record and the care plan.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the resident's right to be free from abuse for one of three residents reviewed for abuse (Resident 127) when the staff member directed inappropriate and derogatory language toward the resident. This failure had the potential to cause psychological harm or emotional harm to Resident 127.Findings:A review of Resident 127's admission Record indicated Resident 127 was admitted to the facility on [DATE], with diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke).A review of Resident 127's History and Physical, dated July 17, 2025, indicated Resident 127 had the capacity to understand and make decisions.On September 24, 2025, at 4:58 p.m., during an interview with Resident 127, Resident 127 stated Licensed Vocational Nurse 3 (LVN 3) called him [NAME] [mother f***r],Come get your meds, [NAME]. Resident 127 stated, he was shocked, he could not react and thought that the licensed nurse was unprofessional.On September 25, 2025, at 2:51 p.m., during an interview with LVN 4, LVN 4 confirmed the incident occurred. LVN 4 stated she was at the nurse's station with Resident 127, when she heard LVN 3 said something inappropriate to Resident 127.On September 25, 2025, at 3:10 p.m., during an interview with the Director of Nursing (DON), the DON stated Resident 127 had reported to a staff member that a nurse said something inappropriate to him. The DON stated Resident 127 told her, he had been called a vulgar name by LVN 3. The DON stated staff were expected to speak respectfully to all residents and the language allegedly used by LVN 3 was inappropriate and inconsistent with facility expectations.On September 25, 2025, at 3:33 p.m., during an interview with LVN 3, LVN 3 stated, she was informed by the DON that the resident made an allegation of verbal abuse. LVN 3 stated, she and Resident 127 had good rapport and they would joke around, saying inappropriate things, sexual remarks and cuss too. LVN 3 stated on September 24, 2025, when Resident 127 was at the nurse's station and she was preparing to administer his medications, she could have said come on, [NAME], let me give your meds.On September 25, 2025, at 5:25 p.m., during an interview with Resident 127, he stated, he felt the language used by LVN 3 was inappropriate and derogatory, and he considered it verbal abuse.A review of the facility policy and procedures titled, Abuse, neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, indicate, .Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation .Protect residents from abuse .from anyone including .facility staff .A review of the facility's policy and procedure titled, Resident Rights, revised February 2021, indicated, .Employees shall treat all residents with kindness, respect and dignity.be free from abuse, neglect, misappropriation of property, and exploitation .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) to the resident or resident representative at the time of transfer to an acute care hospital for one of three residents reviewed for closed records (Resident 1). This failure had the potential for residents and/or their RPs not to be fully informed of their right to request a bed hold or to return to the facility after hospitalization, which could result in an inappropriate discharge.Findings: A review of Resident 1's records indicated Resident 1 was admitted on [DATE], with diagnoses including muscle wasting and atrophy (weakness of the muscles). A review of Resident 1's admission Agreement dated July 23, 2025, indicated, .Bed Holds and readmission If you must be transferred to an acute hospital for seven days or less, we will notify you or your representative that we are willing to hold your bed. You or your representative have 24 hours after receiving this notice to let us know whether you want us to hold your bed for you. A review of the Health Status Note dated August 25, 2025, at 9:28 a.m., indicated, .order to send resident to (acute hospital) for hernia/abd (abdominal) pain. Needs cannot be met at facility. Noted and carried out. A review of the Notice of Proposed Transfer/Discharge dated August 26, 2025, indicated, .notifications.my/our signature confirms that I/we have received a written copy of the Notice of Proposed Transfer/Discharge and, if applicable, the State Bed Hold Notice (including the facility's bed hold policy).Resident notification and verification of receipt of notice.(blank).date of resident representative notification and verification of receipt of notice.(blank). There was no documented evidence the facility provided a written bed hold notice for Resident 1 or their representative post discharge from the facility on August 25, 2025. On September 24, 2025, at 4:04 p.m., a concurrent interview and record review was conducted with the Social Service Director (SSD). He stated he was unsure of the process for a bed hold order but that his responsibility was to alert the family, resident or their representative and the Ombudsman regarding the notification of transfer and/or discharge. The SSD stated, he spoke to the ex-wife of Resident 1 and that a discharge notice was provided. The SSD further stated it was the responsibility of the nursing staff to provide the bed hold notice and such notice should be provided to the resident. On September 24, 2025, at 4:45 p.m. a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN) 4, LVN 4 stated when a resident was hospitalized , a physician order or a seven-day bed hold was obtained. LVN 4 stated there was no other forms used to indicate a resident had a bed hold or that the resident or representative had been notified by the nursing staff. LVN 4 further stated the licensed nurses placed the orders and did not send the written bed hold notice to the resident or representative. On September 24, 2025, at 4:52 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated the documentation of the notification of bed hold should have been noted in the medical record. The DON stated the nursing staff were responsible for communicating and sending the written bed hold notice to the resident or resident representative. The DON stated the written notice should have been sent to Resident 1 or Resident 1's representative which was the ex-wife, and the notification should have been documented. On September 24, 2025, at 4:58 p.m. an interview was conducted with the facility Administrator (FA). The FA stated that proper procedures for informing Resident 1's representative about the bed hold had not been followed. The FA stated although he had notified the ex-wife by phone, no notation was made, the required admission form outlining bed hold rights was not provided, and written documentation of the policy was missing from both the resident's records and the discharge/transfer form. The FA stated, the written notice should have been provided according to the facility protocols. A review of the facility policy titled Bed-Holds and Returns dated October 2022, indicated, .Residents and/or representatives are informed (in-writing) of the facility and state.bed hold policies.All (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents/representatives are provided written information regarding the facility and stated bed -hold polices, which address holding or reserving a residents' bed during periods of absence.(hospitalization).residents, regardless of payer source, are provided written notice about these policies at least twice.notice 1.well in advance of any transfer.in admission packet.and.notice 2.at the time of transfer.within 24 hours.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure incontinence care was provided in a timely manner, consistent with the resident's care needs, for one of one resident reviewed for dignity (Resident 116).This failure had the potential for Resident 116, to be prone to develop urinary tract infection, or increased risk for impaired skin integrity and to prevent her highest psychosocial wellbeing. On September 23, 2025, at 10:30 a.m., during a concurrent observation and interview with Resident 116, Resident 116 was in bed, alert, and interviewable. Resident 116 stated she used her call light during the night shift to request assistance for a brief change. Resident 116 stated, a staff member came in, turned off her call light, and did not return. Resident 116 stated, she again activated her call light, but no staff responded. Resident 116 stated, she remained soaked in urine from her shoulders to her toes, her pad and blanket were saturated. Resident 116 stated, she called her Responsible party last night (September 22, 2025), who in turn called the nurse's station, and only then did staff respond and provide incontinence care the following morning. A review of Resident 116's admission record indicated Resident 116 was admitted to the facility on [DATE], with diagnoses including fracture of right acetabulum (hip socket).Resident 116's History and Physical dated September 5, 2025, indicated .has fluctuating capacity to make decisions. A review of Resident 116's MDS (minimum data set- an assessment tool) dated September 11, 2025, indicated .Functional Abilities - admission .Toilet transfer .Dependent .A review of Resident 116's Care Plan dated September 11, 2025, indicated .The resident is frequently incontinent of bladder and increased risk for impaired skin integrity .Interventions.Brief Use: The resident uses disposable briefs. Change (q 2 hours- every two hours) and prn (as needed).On September 25, 2025, at 4:09 a.m., during an interview with Registered Nurse (RN) 1, RN 1 stated Resident 116 was non-ambulatory and dependent on staff for continence care. RN 1 further stated CNA assigned to Resident 116 should conduct brief check at least every two hours. On September 25, 2025, at 4:15 a.m., during an interview with CNA 1, CNA 1 stated he learned residents' need on his run during shift report. He further stated he worked the night shift, on September 22, 2025. CNA 1 stated he first changed Resident 116's brief at around 11:30 p.m., and he then last saw Resident 116 when he refilled her water pitcher at around 4:30 a.m. CNA 1 stated, he did not check or change her brief during that time. On September 25, 2025, at 8:36 a.m., during an interview with Licensed Vocational Nurse (LVN) 8, LVN 8 stated when she changed Resident 116' s patch earlier in the shift, the resident told her she was a bit wet. LVN 8 stated, she failed to inform the CNA that the resident required brief checks every two hours, per care plan. LVN 8 stated, the resident had increased risk for urinary tract infection and skin breakdown when left in a wet brief. On September 25, 2025, at 5:24 p.m., during an interview with Resident 116, Resident 116 stated it was wrong for anyone to be left soaking in urine all night. A review of facility policy and procedure titled Resident Rights, dated February 2021, indicated .Employee shall treat all residents with kindness, respect and dignity .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure physician-ordered nutritional interventions were implemented for two of three residents reviewed for nutrition (Residents 63 and 64) when:1.Resident 63 did not receive an ordered extra egg at breakfast; and2.Resident 64 did not receive Boost GC (Boost Glucose Control- blend of protein, carbohydrates and fat to help manage blood sugar levels as part of a balanced diet) as prescribed during medication administration. These failures had the potential to compromise the residents' nutritional status and delay healing in a resident population with identified nutritional risks. Findings:1.On September 24, 2025, a review of Resident 63's admission record indicated Resident 63 was admitted to the facility on [DATE], with diagnoses including pressure ulcer stage four (full-thickness tissue loss extending into deep tissues, exposing muscle, tendon, or bone). A review of Resident 63's Physician Order, dated August 24, 2025, indicated .Add one (1) extra egg at breakfast.for Nutrition and Decub (decubitus ulcer- damage skin and underlying tissue) Protocol. A review of Resident 63's Care Plan, initiated August 31, 2025, indicated .Focus-Nutritional Risk: Resident has the potential for altered nutrition.Goal: Will not have worsening in skin condition.Intervention-Provide diet.per physician order. A review of Resident 63's meal ticket, dated September 24, 2025, indicated the ordered extra egg was not included. On September 24, 2025, at 7:50 a.m., during a concurrent breakfast tray line observation and interview with the Dietary Service Supervisor (DSS), the DSS stated Resident 63's breakfast tray did not include the ordered extra egg. The DSS stated she was not notified by the nursing staff of the diet-related physician order for an extra egg for Resident 63. The DSS stated nursing was responsible for communicating diet orders to the kitchen. The DSS stated, failure to provide the extra egg could result in the resident not receiving needed protein to support wound healing. On August 25, 2025, at 11:04 a.m., during an interview with LVN 5, LVN 5 stated the expectation was that when licensed nurse received a diet-related physician order, the licensed nurse should complete a diet order slip and communicate verbally and in writing to dietary staff. On August 25, 2025, at 11:19 a.m., during an interview with LVN 6, LVN 6 stated she received the physician order for an extra egg and did not write the order on the diet slip nor did she notify dietary staff. LVN 6 further stated should have communicated the order as required. 2. A review of Resident 64's admission record indicated Resident 64 was admitted to the facility on [DATE], with diagnoses which included unspecified protein calorie malnutrition (a nutritional disorder). A review of Resident 64's Physician Order, dated August 1, 2025, indicated .BOOST GLUCOSE CONTROL 1 CARTON two times a day for SUPPLEMENT .WITH MEDPASS. On September 24, 2025, at 8:41a.m., during an interview with LVN 7, LVN 7 stated she had finished administering medications to Resident 64. LVN 7 stated, Resident 64 had an order for Boost Glucose Control and she should have prepared and administered the ordered Boost Glucose Control during med pass. LVN 7 stated the supplement should have been given as ordered so that the resident could receive necessary nutrients to promote weight gain and improve nutritional status. A review of the undated facility policy and procedure titled Physician Orders, Accepting, Transcribing, Implementing, indicated .licensed nursing personnel will ensure written telephone and verbal order will be implemented .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the necessary care and services to maintain a peripheral intravenous (PIV - the administration of fluids, medications directly into a vein) for one of three residents reviewed for parenteral/IV fluids (Resident 95) when: 1. A physician's order was not in place for the PIV.2. PIV site was not documented as assessed and the dressing was not changed per facility policy; and3. A care plan was not initiated to address care and monitoring of the PIVThese failures had the potential to place Residents 95 at risk for infection and injury.Findings: A review of Resident 95's records was conducted. Resident 95 was admitted to the facility on [DATE], with diagnoses which included diabetes (high blood sugar) and urinary tract infection (UTI - kidney infection). A review of Resident 95's Minimum Data Set (MDS - an assessment tool) dated September 17, 2025, indicated a Brief Interview of Mental Status (a tool to assess cognitive function of an individual) score of 13 (cognitively intact). A review of the Physicians Order Summary for the month of September 2025, indicated, .NS (normal saline - a solution of salt and water) 1L (liter- a unit of measurement) IV (intravenous) Bolus (a single, large dose of medicine) .one time only for elevated blood sugar for 1 day. A review of the Nurses Progress Note dated September 13, 2025, at 12:27 a.m., indicated, .22g (gauge -needle thickness size) IV catheter (hollow tube inserted into a vein by a needle) inserted on the right wrist with one attempt.0.9% NS 1L bolus started.author: Registered Nurse (RN) Further review of Resident 95's records indicated, there was no documented evidence a physician's order was in place prior to PIV insertion and there was no documentation of assessment or monitoring of the IV site from September 13 to September 23, 2025. Additionally, there was no documented care plan initiated for the care of the PIV. On September 23, 2025, at 10:14 a.m., a concurrent observation and interview were conducted with Resident 95. Resident 95 was observed alert and lying in bed with a PIV line dressing on the right hand, dated September 13, 2025, with an illegible time and initials. Resident 95 stated he was unsure how long he had the PIV in place and stated he did not want to accidentally pull it out. On September 23, 2025, at 10:23 a.m., a concurrent observation and interview were conducted with Licensed Vocational Nurse (LVN 5) in Resident 95's room. LVN 5 stated Resident 95 had a 22g PIV on his right wrist dated September 13, 2025. LVN 5 stated the dressing was over 7 days, and per facility policy, the dressing should have been changed to prevent infection issues and ensure the IV remained intact. On September 23, 2025, at 10:27 a.m., a concurrent interview and record review of Resident 95's records were conducted with LVN 5. LVN 5 stated Resident 95 had a physician order for a 1L IV bolus due to Resident 95's elevated blood sugar. LVN 5 stated RNs were responsible for carrying out IV orders. LVN 5 stated there was no way to confirm whether the PIV site assessments were completed and further stated, the lack of monitoring posed a risk for infection. On September 23, 2025, at 3:10 p.m., a concurrent interview and record review of Resident 95's records were conducted with RN 2. RN 2 stated on September 12, 2025, Resident 95's blood sugar was elevated and there was a physician's order for a 1L NS bolus. RN 2 stated he inserted the PIV on the resident and forgot to verify whether a physician's order was in place for the PIV insertion. RN 2 stated there was no physician order for PIV insertion. RN 2 further stated, he should have initiated a care plan and monitoring for the PIV to avoid infection issues. On September 25, 2025, at 2:04 p.m., a concurrent interview and record review of Resident 95's records were conducted with the Director of Nursing (DON). The DON stated the facility had a standard order set for IV monitoring and it was not followed for Resident 95 because the physician order was not entered completely. The DON stated documentation should be indicated in the medical administration record (MAR) and/or in a progress note to confirm that the assessments for the PIV were completed. The DON stated there should have been a care plan to make sure the ongoing care and to prevent any infection issues. The DON stated, the RNs should make sure that a physician order was in place before inserting a PIV. A review of the facility's policy and procedure titled Peripheral and Midline IV (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dressing, dated 2001, indicated, .The purpose of this procedure is to prevent complications associated with intravenous therapy.perform site care and dressing change.at least every 7 days for transparent semi permeable membrane (TSM).inspect the skin, dressing and securement of device for signs of complications.the following should be documented in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the dialysis (a treatment which performs the work of the kidneys when they could no longer function properly) pressure dressing was removed two hours after arrival from dialysis as ordered, for one out of two residents reviewed for dialysis (Resident 148).This failure had the potential for infection and/or clotting to Resident 148's dialysis access site.Findings:On September 25, 2025, at 8:47 a.m., an observation and interview were conducted in Resident 148's room. Resident 148 was lying in bed, in a semi-upright position. His dialysis access site, located on his left upper arm, was covered with a pressure dressing. Resident 148 stated the dressing was to be removed the previous day upon returning from dialysis, they forgot.On September 25, 2025, at 9:00 a.m., a concurrent observation and interview was conducted with the Licensed Vocational Nurse (LVN 7). LVN 7 stated the pressure dressing should have been removed yesterday, within two hours of the resident's return from the dialysis clinic, in order to prevent infection. On September 25, 2025, at 3:10 p.m., an interview was conducted with the Director of Nursing, (DON). The DON stated that the nursing staff should have removed the dialysis pressure dressing as ordered, within two hours post dialysis treatment to prevent further complications such as clotting and infection.A review of Resident 148's, admission Record indicated Resident 148 was admitted to the facility on [DATE], with diagnoses which included ESRD (End Stage Renal Disease-irreversible kidney failure).A review of Resident 148's, History and Physical, dated, September 12, 2025, indicated, .has the capacity to understand and make decisions.A review of Resident 148's Order Summary Report for the month of September 2025, indicated, . dialysis [name of facility] Mon [Monday]/Wed [Wednesday]/Fri [Friday] one time a day every Mon, Wed, Fri .remove bandage two hours after arrival from dialysis every shift.A review of the facility's policy and procedures (P&P) titled, Hemodialysis Access Care , dated September 2010, indicated, .to prevent infection and/or clotting: .keep the access site clean at all times.check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care and at regular intervals .

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	555309	A. Building B. Wing	11/24/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure one oral relief sore throat spray stored in a medication cart was properly labeled. This failure had the potential for the residents to receive unnecessary medications or for medication error to occur. Findings:On September 25, 2025, at 11:32 a.m. a concurrent observation and interview were conducted with Licensed Vocational Nurse (LVN) 9 at the medication cart located in the East Station.An unlabeled bottle of Phenol 1.4 % (medications that temporarily induce a loss of sensation) oral relief sore throat spray was found in the cart, available for use. The bottle was half-full, the cap was broken, and there was no resident name, identifier or pharmacy label. LVN 9 stated she was unable to identify which resident the spray belonged to or when it was last used. LVN 9 stated the bottle had been opened and used, as half of the fluid in the bottle was visible. LVN 9 state she was unsure of how long the medication had been in the cart. LVN 9 stated it was the medication nurse responsibility to check the carts so that there were not unlabeled or expired medications available for use. LVN 9 stated I will check my carts normally at the beginning of each shift and I did not notice this; it should be removed because it has no label. LVN 9 stated unidentified items should be discarded and not be in the carts without a label because someone could use it unintentionally. LVN 9 stated residents were allowed to order over the counter medications but that the medications should be identified with a label indicating the residents name, orders for administration and authorized by a physician. A review of the facility policy and procedure titled, Storage of Medications dated April 2007 indicated, .the facility shall store all drugs and biologicals in a safe, secure, and orderly manner.the nursing staff shall be responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner.resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident's food preference was honored for one of three residents reviewed for nutrition (Resident 120). This failure had the potential to result in the resident refusing meals and experiencing decreased nutritional intake.Findings: On September 22, 2025, at 11:21 a.m. an observation and interview were conducted with Resident 120. Resident 120 stated she was prescribed a regular diet with large portions and disliked milk to drink. Resident 120 stated, they keep bringing me milk and I keep telling them I don't like it. A large note was observed on the resident's table that read in capital letters, .NO MILK PLEASE. Resident 1's meal ticket was observed to list the following: .Notes.Milk for cereal only.Standing.4fl oz (fluid ounce a unit of measure) milk 2% 4 fl oz juice.Orders.8 fl oz. Milk 2% .Dislikes.Milk to drink. On September 24, 2025, Resident 120's record was reviewed. Resident 120 was admitted on [DATE], with a diagnosis which included fracture of right femur (broken leg bone) and diverticulosis of the large intestine (a condition where small pouches [diverticula] form in the wall of the colon (large intestine). A review of the Minimum Data Set (an assessment tool), dated August 11, 2025, indicated Resident 120 had a Brief Interview of Mental Status (a tool to assess cognitive function of an individual) score of 14 (intact cognitive response). A review of the Dietary Interview dated August 8, 2025, indicated, .dislikes.cold cereal. A review of the Order Summary Report dated August 28, 2025, indicated, .NAS (no added salt) diet regular texture.thin consistency, Dislikes milk.Do not serve milk to drink. On September 24, 2025, at 11:47 a.m. an interview and record review was conducted with the Registered Dietitian (RD). The RD stated she was not aware Resident 120 received milk with meals after requesting no milk. The RD stated Resident 120 had an order which indicated don not serve milk to drink. The RD stated the staff serving meals should review the meal tickets prior to serving meals and provide the meals according to the orders, and preferences. The RD further stated Resident 120 should not be served milk. On September 25, 2025, at 8:37 a.m., an observation and interview was conducted with Certified Nursing Assistant CNA 2. CNA 2 was observed to serve milk to Resident 120 in her room. CNA 2 was observed to walk away from Resident 120's room with milk in hand. CNA 2 stated the resident told her to remove the milk from the tray. CNA 2 stated CNAs should check the meal tickets to ensure residents receive the correct diet and that the dislikes are honored. On September 25, 2025, at 8:39 a.m. a follow up interview was conducted with Resident 120. Resident 120 stated she was served milk and that she asked the staff to remove it from her tray before leaving the room. On September 25, 2025, at 8:58 a.m. a concurrent interview and record review was conducted with the Dietary Supervisor (DS). The DS stated the diet order for Resident 120 indicated Resident 120 did not want milk and dislikes milk. A review of the clinical dietary interview conducted by the DS on August 28, 2025, and the meal ticket dated September 25, 2025, was conducted with the DS. The DS stated there is cold cereal listed as a dislike and Resident 120 should not have received milk with her meals since cold cereal means milk, and the order on the meal ticket says 8floz of milk 2%. The DS stated, she should not have milk. A review of the facility's policy and procedure titled, Resident Food Preferences, dated July 2017, indicated, Individual food preferences will be assessed upon admission and as soon as practicable.modifications to diet will only be ordered with the resident's or representative's consent .staff.will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician-ordered fortified diet (high calorie, high protein diet) were provided as prescribed for two of eight residents reviewed for nutrition (Residents 98 and 125).This failure had the potential to reduce calorie and protein intake, decrease palatability of meals, and negatively affect nutritional status for these residents, in a facility with a population of 140. Findings:A review of facility undated document titled Fortified Menu Plan, indicated .This plan provides an additional 300-400 calories and 3-4 grams of protein per day.Lunch and Dinner.Meat per menu.Possible Fortified Additions.Extra 1 oz (ounce- unit of measurement) of gravy or sauce. On September 24, 2025, at 1 p.m., during a lunch tray line observation, the meal trays for Resident 98 and Resident 125 were not provided with the required extra one ounce of gravy.On September 24, 2025, at 1:17 p.m., during a concurrent observation and interview with the Dietary Aid (DA) and the Dietary Supervisor (DS), the DA stated, the cart containing meals for Residents 98 and 125 was checked and ready for delivery. The DA with the DS compared the meal trays with the printed meal tickets, the DS stated Residents 98 and 125 trays did not contain the required extra ounce of gravy. The DS further stated that residents on a fortified diet must receive the added gravy per physician order and that additional protein assists with weight gain and wound healing. 1. A review of Resident 98's admission Record indicated Resident 98 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer stage 4 (full-thickness tissue loss extending into deep tissues, exposing muscle, tendon, or bone). A review of Resident 98's care plan dated October 28, 2024, indicated .Focus.Malnutrition (nutritional disorder) .Resident has a diagnosis of protein calorie malnutrition (a nutritional disorder) as evidenced by malnutrition .Interventions.Fortified Diet.Provide diet per physician order. A review of Resident 98's Physician Order dated August 23, 2025, indicated .Fortified Diet.2. A review of Resident 125's admission Record indicated Resident 125 was admitted to the facility on [DATE], with diagnoses which included generalized weakness. A review of Resident 125's care plan dated April 18, 2024, indicated .Focus.Malnutrition.Resident is at risk for Malnutrition/Weight Loss.Intervention.Fortified diet. A review of the facility's undated policy titled Diet Order indicated .Diet orders as prescribed by the Physician will be provided by the Food and Nutrition Services Department.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure required personal protective equipment (PPE - specialized clothing or equipment worn by staff to protect themselves and others from exposure to infectious agents) was readily available on the PPE cart for one of one resident reviewed for infection control (Resident 8).This failure increased the risk of transmission of infection to residents and staff. Findings:A review of Resident 8's admission Record indicated Resident 8 was re-admitted to the facility on [DATE], with diagnoses including ESBL infection (Extended-Spectrum Beta Lactamases - a highly contagious bacterial infection requiring the resident to be on contact precaution (a type of precaution used to prevent the spread of infections that are transmitted to through direct physical contact).On September 24, 2025, at 3:38 p.m., during a concurrent observation and interview with the Housekeeping Supervisor (HS), Resident 8's PPE cart was observed without disposable gowns. The HS stated, she was responsible for stocking the PPE carts and stated the PPE cart was missing disposable gowns. The HS stated the cart should contain the proper PPE required for staff to prevent infection transmission.On September 25, 2025, at 2:01 p.m., during an interview with the Infection Preventionist (IP), the IP stated Resident 8 was on contact precautions, and the isolation cart should have disposable equipment available for staff to properly perform their duties. On September 25, 2025, at 3:10 p.m., during an interview with the Director of Nursing (DON), the DON stated, for contact precautions, required PPE, including gowns, gloves, masks, must be stocked and available for staff to use to prevent infection transmission. The DON stated any staff member who observed that the isolation cart was not fully stocked should restock it. A review of the facility policy and procedure titled, Infection Prevention and Control Program, dated December 2023, indicated, .important facets of infection prevention include.implementing appropriate enhanced barrier and transmission-based precautions when necessary .