STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	09/11/2025

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Sunrise Post Acute	3476 W. Wilson St. 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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility assessment was reviewed and updated annually and as needed.This failure resulted in an inaccurate evaluation of the facility's population and resources needed to provide the necessary care and services for the residents.Findings:On September 11, 2025, at 4:03 p.m., a concurrent interview and record review was conducted with the Administrator (ADM). The ADM stated he was responsible for conducting the facility assessment. The ADM stated the last facility assessment was on July 24, 2024. The ADM stated the facility assessment should have been done annually. During a review of the facility assessment dated [DATE], the ADM stated the facility assessment should reflect the accurate census of the facility and the cultural needs and services being rendered to that served population. The ADM stated that the facility assessment dated [DATE], failed to accurately detail the cultural assessment, staff types, services rendered, and building plant needs and should have accurately reflected these areas.A review of the facility policy and procedure titled Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities .Rules and Regulations, dated August 18, 2017, indicated .The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for it's residents competently during both day-to-day operations and emergencies.The facility must review and update that assessment, as necessary, and at least annually.

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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility Quality Assurance and Performance Improvement Program (QAPI) failed to identify and address their deficient practice involving physician visits (cross reference F0712).This failure has the potential to put residents at risk for unidentified medical conditions which could result in inadequate quality of care and services.Findings:On September 11, 2025, at 4:33 p.m., an interview was conducted with the Administrator (ADM) and Medical Records (MR). The MR stated the QAPI Committee meets on a quarterly basis and as needed. The MR stated the last QAPI meeting was held on July 23, 2025, where they discussed falls, weight variance, elopement, and theft and loss. The ADM stated the QAPI team was unaware of the deficient practice regarding the nurse practitioner (NP) completing the initial visits. The ADM stated the facility did not have a system in place to ensure initial resident visits were conducted by the primary physician. A review of the facility policy and procedure titled Quality Assurance and Performance Improvement (QAPI) Program - Analysis and Action, dated March 2020, indicated .QAPI committee is designed to identify and address quality deficiencies.The QAPI committee is responsible for analyzing identified problems, establishing corrective actions, measuring progress against the established goals and benchmarks, communicating information to staff and residents, and reporting findings to the Administrator and governing board.

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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 - Some	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 interview and record review, the facility failed to ensure the fluid intake and output in 24 hours was accurately monitored, recorded, and evaluated as ordered by the physician for one of one resident reviewed (Resident 19). This failure had the potential for the resident to experience complications associated with fluid deficit and/or fluid overload.Findings:On September 9, 2025, Resident 19's record was reviewed. Resident 19 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease (ESRD - severe and irreversible loss of kidney function that requires ongoing treatment to maintain life), congestive heart failure (CHF - chronic condition where the heart cannot pump blood effectively enough to meet the body's needs leading fluid buildup in the lungs, legs, and other parts of the body),dementia (progressive impairment of intellectual functioning, memory, and abstract thinking), and dependence on renal dialysis (medical procedure that removes waste products and excess fluid from the blood when the kidneys are unable to do so).The following medical records were reviewed, -The History and Physical, dated August 5, 2025, indicated Resident 19 did not have the capacity to understand and make decisions;-The Physician's Order, dated August 26, 2025, indicated Resident 19 was to receive dialysis treatment three times a week every Tuesday, Thursday, and Saturday;- The ,Physician's Order, dated August 22, 2025, indicated, .Intake and Output Monitoring .every evening shift Calculate and record total Intake and Output FOR THE DAY .Order Date 08/22/2025 .Intake and Output Monitoring .every shift Monitor and record OUTPUT, include urine, emesis (vomiting), and other drainage .Order Date 08/22/2025 .Intake and Output Monitoring .every shift Monitor and record PO (oral) .;- The electronic Medication Administration Record (eMAR) dated August 1 to 31, 2025, indicated the Licensed Nurses (LN) did not consistently monitor, calculate, and record, Resident 19's total fluid intake and output every evening shift from August 22 to 31, 2025. The recorded average fluid intake per shift was from (lowest) 240 cc (cubic centimeter - unit of measurement) to (highest) 600 cc. The total fluid output recorded per shift varied from a combination of fluid measurement (cc) and/or number of episodes Resident 19 urinated during the shift (e.g. x 1);- The eMAR dated September 1 to 30, 2025, indicated the LN did not consistently monitor, calculate, and record, Resident 19's total fluid intake and output every evening shift from September 1 to 9, 2025. The recorded average fluid intake per shift was from (lowest) 120 cc to (highest) 480 cc. The total fluid output recorded per shift varied from a combination of fluid measurement (cc) and number of episodes Resident 19 urinated during the shift;- The NUTRITIONAL RISK ASSESSMENT, completed by the Registered Dietitian (RD) and dated August 25, 2025, indicated, .Estimated Nutritional Needs .Fluids: 1750-2100 mL(milliliter- unit of measurement)/day .; and- The following Care Plan Report, indicateda.Focus .Resident is at risk for malnutrition due to anemia, dementia, depression, malnutrition, mechanically altered diet, recent acute illness, protein calorie malnutrition .Goal .Will maintain adequate nutritional status .Intervention .Assist with meals/fluids as needed .Encourage adequate nutrition and hydration . Dated August 22, 2025;b.Focus .Resident requires .Hemodialysis .Interventions .Calculate the total intake and output at the end of each 24-hour period to determine fluid balance . Dated August 22, 2025, andc.At risk for dehydration or electrolyte imbalance related to acute illness, cognitive deficit, Dementia .ESRD .Poor fluid intake .Encourage increased PO fluids if not contraindicated .On September 10, 2025, at 9:44 a.m., Certified Nursing Assistant (CNA) 2 was interviewed. CNA 2 stated she was the CNA assigned to Resident 19. CNA 2 stated Resident 19 was a dialysis resident. CNA 2 stated she was told Resident 19 was not on a fluid restriction and he was not monitored for fluid intake and output.On September 10, 2025, at 9:42 a.m., an interview with concurrent record review was conducted with Registered Nurse (RN) 1. Resident 19's physician orders for fluid intake and output monitoring, eMAR for August and September 2025, and Nutritional Risk Assessment (August 25, 2025) were reviewed with RN 1. In a concurrent interview, RN 1 stated:-The LNs were monitoring the fluid intake in the August and September 2025 (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eMAR but they are not recording the total fluid intake in 24 hours as ordered by the physician. RN 1 stated the total fluid output in 24 hours were also not accurately recorded in the eMAR because some LN are documenting the fluid output through fluid cc and some LN are recording the number of episodes Resident 19 urinated during the shift.-She did not know why the physician ordered a fluid intake and output monitoring on Resident 19 since he was not on fluid restriction even if he was a dialysis resident. RN 1 verified the Registered Dietician (RD)'s Nutritional risk Assessment, dated August 25, 2025, indicated Resident 19's estimated fluid nutritional needs was at 1750-2100 mL/day. RN 1 further stated, basing it on the total fluid amount recorded per day since August 22, 2025, Resident 19's total fluid intake intake was from approximately 800 cc to 920 cc per day. -Resident 19 did not meet the fluid nutritional needs of 1750-2100 mL/day as indicated on the Nutritional Assessment by the RD on August 25, 2025.-The LNs were documenting the fluid intake every shift but were not recording the total fluid intake in the evening shift as ordered by the physician. She was not sure how the LNs were recording Resident 19's fluid intake per shift;-There was no evaluation done on Resident 19's fluid intake and output since it ordered by the physician on August 22, 2025, and Resident 19 did not have a care plan developed specific to address Resident 19's fluid intake and output monitoring.-There was no documentation Resident 19's fluid intake in a day, was less than the required nutritional needs, was referred to the physician. RN 1 stated if the fluid intake in a day was too high, Resident 19 might develop fluid overload, and/or if he was not taking much fluid he might get dehydrated (having lost a large amount of water from the body).On September 11, 2025, at 11:05 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated, if Resident 19's fluid intake in a day was below the required nutritional fluid intake in a day, Resident 19 might get dehydrated. The DON stated the low fluid intake per day should have been reported to the physician and Resident 19 should have been monitored for signs and symptoms of dehydration and/or other complications such as fluid overload. The DON stated this was not done.The facility's policy and procedure titled, .Intake, Measuring and Recording, dated October 2010, was reviewed. The policy indicated, .The purpose of this procedure is to accurately determine the amount of liquid a resident consumes in a 24-hour period .Verify that there is a physician's order for this procedure and/or that the procedure is being performed per facility policy .General Guidelines .Record the fluid intake as soon as possible after the resident has consumed all the fluids .At the end of your shift, total the amounts of all liquids the resident consumed .Record all fluid intake on the intake and output record in cubic centimeters .Documentation .The following should be recorded in the resident's medical record, p[er facility guidelines .The date and time the resident's fluid intake was measured and recorded .The amount (in MLs) of liquid consumed .The type of liquid consumed .If the resident refused treatment, the reason (s) why and the intervention taken .Reporting .Notify the supervisor if the resident refuses the procedure .Report other information in accordance with the facility policy and professional standards of practice.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician conducted the initial visit for five of ten sampled residents (Residents 28, 35, 26, 22, 47).These failures had the potential to result in unidentified medical conditions and/or insufficient provision of medical treatment.Findings:On September 10, 2025, Resident 28's record was reviewed. Resident 28 was admitted to the facility on [DATE].The document titled, History and Physical, dated June 25, 2025, indicated Resident 28 had the capacity to make decisions. The document further indicated, .More than 30 minutes was spent in the evaluation and treatment of this patient during this encounter including: history and physical examination, review of nursing notes, medication reconciliation, review of pertinent diagnostic testing, documentation in the clinical record, patient counseling and communication with the nursing staff and responsible parties .I have discussed my evaluation and findings with my supervising physician, (Physician 1) who agrees with the evaluation, assessment, and plan .electronically signed (NP 1) .On September 10, 2025, at 3:11 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated NP 1 conducted the initial History and Physical (H&P) comprehensive assessment on Resident 28 and not the primary physician. The DON stated Physician 1 should have conducted the initial H&P comprehensive assessment on Resident 28.On September 10, 2025, at 3:30 p.m., a record review with a concurrent interview was conducted with Medical Records (MR). The MR stated NP 1 was the NP under the supervision of Physician 1. The MR stated NP 1 usually did the initial H&P on Physician 1's new admit residents.On September 11, 2025, at 11:25 p.m., a record review with concurrent interview was conducted with the DON. The following residents' initial H&P assessment was conducted by NP 1:-Resident 35 was admitted to the facility on [DATE]. A change in physician, per resident request, from Physician 2 to Physician 1 was done on August 11, 2025. NP 1 did the initial H&P assessment on August 11, 2025;-Resident 26 initial H&P assessment on August 6, 2025;-Resident 22 initial H&P assessment on July 18, 2025; and-Resident 47 initial H&P assessment on July 26, 2025.In a concurrent interview, the DON stated NP 1 conducted the initial H&P assessments on Residents 35, 26, 22, and 47. The DON stated Physician 1 countersigned NP 1's initial H&P report but it was NP 1 who came and did the assessments. The DON stated the primary physician (Physician 1) should have conducted the initial H&P assessments on these residents.The facility policy and procedure titled, .Attending Physician Responsibilities, dated August 2014 was reviewed. The policy indicated, .The Attending Physicians shall be the primary practitioner's responsible for providing medical services and coordinating the healthcare of each resident in the facility .Each Attending Physician will be responsible for the initial and subsequent resident care .The Attending Physician will assess new admission in timely fashion, according, to the individual medical stability .

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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 residents' right to self-administer medications for one of two residents (Resident 26) reviewed, when one opened box of Systane (eyedrops to prevent dryness of the eyes), a box of Lmnoop eczema relief cream (eczema-skin condition causing itching and dryness), and a bottle of Migrastil pain roll-on (pain relief cream) were observed on top of the resident's bedside table.This failure had the potential for Resident 26 to self-administer medications without a physician's order.Findings:On September 8, 2025, at 9:34 a.m., Resident 26 was observed lying in bed, watching television. One box of Lmnoop eczema cream, one box of Systane eyedrops, and one bottle of migrastil pain block roll-on were observed inside of a small box on top of Resident 26's bedside table. The box of Systane eyedrops, the box of Lmnoop eczema cream, and the bottle of migrastil pain roll-on were not labeled with Resident 26 identifiers. In a concurrent interview with Resident 26, she stated she self-administers the eye drops to herself five times daily. She further stated she administers the Lmnoop eczema cream and migrastil pain roll-on as needed. Resident 26 stated she has had all three medications at the bedside since shortly after her admission. Resident 26 further stated the facility has never evaluated her for self-administration of medication.On September 8, at 10:01 a.m., during a concurrent observation and interview, Licensed Vocational Nurse (LVN) 2 verified there was one box of Lmnoop eczema cream containing one unlabeled tube of cream, one unlabeled box of Systane eyedrops containing one open unlabeled bottle of eye drops, two unopened unlabeled bottles of eyedrops, and one unlabeled bottle of Migrastil pain roll-on. LVN 2 was observed removing the three named medications from Resident 26's bedside table.On September 8, 2025, Resident 26's medical record was reviewed.The admission record indicated Resident 26 was admitted to the facility on [DATE], with diagnoses which included fibromyalgia (widespread body pain), osteoarthritis (stiffness and swelling of joints), hypertension (high blood pressure), and diabetes mellitus (high blood sugar).The history and physical completed on August 6, 2025, indicated Resident 26 had the capacity to make informed decisions.Resident 26's medical record did not indicate a physician's order for the medications Lmnoop eczema cream, Systane eye drops, or Migrastil pain roll-on.Resident 26's medical record did not indicate an assessment for self-administration of medications was conducted.On September 9, 2025, at 3:40 p.m., a concurrent interview and record review was conducted with LVN 2. LVN 2 stated Resident 26 should not have medications at the bedside without an assessment for self-administration. LVN 2 stated the facility process for self-administration is for the physician to be notified for resident's desire to self-administer medication, assess the resident, obtain a physician's order to educate resident on self -administration, label residents bedside medication, and inform resident to notify nursing of administration of the bedside medication. LVN 2 stated Resident 26 did not have a physician's order dated on or before September 8, 2025, for the medications Lmnoop eczema cream, Systane eye drops, and Migrastil pain roll-on. LVN 2 stated there was no documented evidence that the Interdisciplinary Team (IDT - group of individual facility members who plan care for the resident) assessed Resident 26 for self- administration of medication. LVN 2 stated Resident 26 did not have a care plan for self-administration of medication. LVN 2 stated Resident 26 should have had a physician orders for the Lmnoop eczema cream, Systane eyedrops, and Migrastil pain roll-on. LVN 2 further stated residents have the right to self-administer and Resident 26 should have been evaluated for self-administration.On September 9, 2025, at 3:47 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated she was not aware of the facility policy and procedure for self-administration of medication. The DON stated the facility does not allow residents to self-administer medication. The DON further stated residents should not have medications at their bedside without a physician's order. The DON stated the nursing staff should be checking residents' rooms for bedside medications.A review of the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy and procedure titled Self-Administration of Medications, dated 2001, indicated .As part of the evaluation comprehensive assessment, 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 resident.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.self-administering residents.the nursing staff determines who is responsible.for documenting that medications are taken. any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge.A review of the facility policy and procedure titled Administering Medications, dated 2001, indicated .Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have decision-making capacity to do so safely.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (Resident 6) was free from unnecessary medications when adequate indications (clinical rationale) for antipsychotic (drug to reduce disordered thinking) use were not documented. This failure had the potential for the resident to experience adverse outcomes from the unnecessary use of the antipsychotic medication such as Neuroleptic Malignant Syndrome (life-threatening reaction), tardive dyskinesia (chronic, involuntary movements), and increased risk of falls that could impair their ability to function at their highest level of physical, mental, and psychosocial well-being.Findings:During a review of Resident 6's Preadmission Screening and Resident Review (PASRR) Level 1 Screening (screening to identify residents if they have a suspected mental illness), dated June 12, 2025, completed by the general acute care hospital prior to the resident's nursing home admission, the PASRR indicated, No, for the Section III - Serious Mental Illness.9. Diagnosed Serious Mental Illness. Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia [mental illness that affects how a person thinks, feels, or behaves] / Schizoaffective [person also experiences mood symptoms] Disorder, or symptoms of Psychosis [severe mental condition where people lose contact with reality], Delusions, and/or Mood Disturbance? Continued review of the PASRR indicated, No, for Section III - Serious Mental Illness.10. Suspected Mental Illness. After observing the individual or reviewing their records, do you believe the individual may be experiencing serious depression or anxiety, unusual or abnormal thoughts, extreme difficulty coping, or significantly unusual behaviors or does the individual actively engage in community mental health services. Further continued review of the PASRR indicated No, for Section III - Serious Mental Illness.11. Psychotropic Medication. Has the individual been prescribed psychotropic medications for Serious Mental Illness. The result of the PASRR Level I Screening was negative for mental illness. During a review of Resident 6's HISTORY AND PHYSICAL [H&P - comprehensive patient assessment] dated June 20, 2025, was reviewed. The H&P indicated Resident 6 was admitted on [DATE], with a history of prostate (part of the male reproductive system) cancer, hypertension (high blood pressure), and atrial fibrillation (medical condition with irregular heart rhythm). During a review of Resident 6's medical record, the physician orders indicated a medication order dated June 18, 2025, for Seroquel (brand name for the antipsychotic medication quetiapine) 100 milligrams (mg - a unit of measurement for dose) by mouth two times a day for Psychosis m/b [manifested by] Striking out with a start date of June 19, 2025, and an end date of July 8, 2025. A continued review of Resident 6's Medication Administration Record (MAR) indicated Seroquel 100 mg was given to the resident two times a day from June 19, 2025, to July 8, 2025. During a review of Resident 6's Minimum Data Set (MDS - clinical assessment of nursing home residents) dated June 25, 2025, the MDS for Section E was reviewed. The box was checked None of the above for E0100. Potential Indicators [signs] of Psychosis. For E0200. Behavioral Symptoms - Presence & Frequency the coding was zero (behavior was not exhibited) for A. Physical behavioral symptoms directed towards others (e.g., hitting, kicking, pushing, scratching, grabbing, abusing others sexually), B. Verbal behavioral symptoms directed towards others (e.g., threatening others, screaming at others, cursing at others) and C. Other behavioral symptoms not directed towards others (e.g., physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds. During a review of Resident 6's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated June 29, 2025, completed by the MDS Nurse (MDS RN), the PASRR indicated, No, for the Section III - Serious Mental Illness.9. Diagnosed Serious Mental Illness. Does the Individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder, Panic Disorder, Schizophrenia [mental illness (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that affects how a person thinks, feels, or behaves] / Schizoaffective [person also experiences mood symptoms] Disorder, or symptoms of Psychosis, Delusions, and/or Mood Disturbance? Continued review of the PASRR indicated, No, for Section III - Serious Mental Illness.10. Suspected Mental Illness. After observing the individual or reviewing their records, do you believe the individual may be experiencing serious depression or anxiety, unusual or abnormal thoughts, extreme difficulty coping, or significantly unusual behaviors or does the individual actively engage in community mental health services. The result of the PASRR Level I Screening was negative for mental illness. During a review of Resident 6's IDT [Interdisciplinary Team - a group of healthcare professionals] PSYCHOTHERAPEUTIC [medication to control behavior or treat thought disorder processes] REVIEW, dated July 8, 2025, the facility document indicated 2.NPI's [non-pharmacological interventions] usually effective. A continued review indicated, 6. IDT/Pharmacist Recommendations, the facility document indicated the Behavior Management Team met with the Psychiatrist [physician with specialized experience in mental health] who reviewed Resident 6's current medication regimen and behaviors. During a review of Resident 6's Nurse Practitioner Note, dated July 8, 2025, the facility document indicated no psychiatric [person's past and current mental health experiences] history. During a review of Resident 6's PSYCHOTROPIC [any drug that affect brain activities associated with mental processes and behavior] SUMMARY SHEET, dated July 10, 2025, the number of behavior episodes/shifts were zero behaviors for the time period from June 1, 2025, to June 30, 2025. During an interview on September 11, 2025, at 10:33 a.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated they have known Resident 6 for a few months. CNA 1 stated, He is alert and can express whatever he needs. He needs a little assistance. Sometimes he puts on clothes himself. [His] personality is pretty good. He is a gentleman. He talks to us very nicely. I have never seen him in a bad mood. When I work with him, he is very nice to me. He cooperates with everything. During an interview on September 11, 2025, at 2:05 p.m., with the MDS Nurse (MDS RN), the MDS RN stated Resident 6's diagnosis was psychosis manifested by striking out. The MDS RN stated, We can't diagnose. It's just a symptom. We have to wait for the Psychiatrist to evaluate. The MDS RN stated the Psychiatrist evaluated Resident 6 on July 8, 2025 (the resident was admitted on [DATE]). During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention and Monitoring, dated March 2019, the P&P indicated, Policy Statement.6. The facility will comply with regulatory requirements related to the use of medications to manage behavioral changes.Management.10. When medications are prescribed for behavioral symptoms, documentation will include: a. Rationale for use.

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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 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, a left elbow skin discoloration, identified on September 9, 2025, was reported and referred to the physician in a timely manner for treatment orders, for one of eight resident's reviewed (Resident 8).This failure has the potential for the resident to experience complications due to the delay in monitoring and treatment.Findings:On September 9, 2025, at 9:43 a.m., an observation with a concurrent interview was conducted with Resident 8. Resident 8 was in bed, alert, and interviewable. Observed on Resident 8's left elbow was a purplish skin discoloration, with skin intact, and with no redness or swelling noted on the surrounding skin area. In a concurrent interview, Resident 8 stated she has had the purplish skin discoloration on her elbow for days and it did not hurt. Resident 8 stated she must have gotten it when the nurses pulled her up for repositioning or when her elbow probably hit the side table on her bed.On September 11, 2025, Resident 8's record was reviewed. Resident 8 was admitted to the facility on [DATE], with diagnoses including dementia (progressive impairment of intellectual functioning, memory, and abstract thinking).The History and Physical, dated March 18, 2025, indicated Resident 8 can make needs known but cannot make medical decisions.The Physician's Order, dated June 24, 2024, indicated to monitor Resident 8 every shift for bleeding, bruising, and skin discoloration related to Plavix (brand name of a blood thinning medication that helps prevent platelets from sticking together, common side effect is bleeding or bruising more easily than usual). The Shower Skin Sheet, dated September 9, 2025, indicated Resident 8 had a shower provided by the Certified Nursing Assistant (CNA). The Shower Skin Sheet indicated the CNA marked no apparent skin issues on Resident 8.The electronic Medication Administration Record (eMAR) dated September 1 to 30, 2025, indicated the Licensed Nurses (LN), monitored Resident 8 for bleeding, bruising and skin discoloration every shift from September 1 to 10, 2025. The eMAR indicated the LNs have not identified new bruising or skin discoloration on Resident 8 during that period.The care plan dated August 30, 2025, indicated, .Resident is at risk for potential bleeding and bruising due to anticoagulant (medication that has the effect of retarding or inhibiting the coagulation {action or process of a liquid, especially blood, changing to a solid or semi-solid state} of blood) therapy .Goal .Signs and symptoms of bruising or bleeding will be promptly identified with interventions to alleviate initiated timely .Interventions .Monitor for bruising or bleeding. Report abnormal findings to the physician .There was no documented evidence the purplish skin discoloration on Resident 8's elbow identified on September 9, 2025, was reported, assessed, and referred to the physician for treatment orders.On September 11, 2025, at 10:10 a.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she was the day shift LN assigned to Resident 8 since Tuesday, [DATE]. LVN 1 stated she did not receive a report from the CNA or LN, on the purplish skin discoloration on Resident 8's left elbow.On September 11, 2025, at 10:20 a.m., an interview with concurrent record review was conducted with the Treatment Nurse (TN). The TN stated she worked as TN on September 9, 2025, and she has not received a report from the nurses that Resident 8 had a skin discoloration on her left elbow. The TN stated Resident 8 was being monitored for bruising and skin discoloration due to Plavix use but the September 2025 eMAR did not indicate Resident 8 had a new skin discoloration on her left elbow.On September 11, 2025, at 10:30 a.m., an observation with a concurrent interview was conducted with the TN and Resident 8. Resident 8 was in her wheelchair doing exercises in the therapy room. TN 1 saw the purplish skin discoloration on Resident 8's elbow and stated, the purplish skin discoloration was not reported to her and it did not have a current treatment order or care plan. The TN further stated when a new skin problem was identified, it was considered a Change in Condition (COC), the LN will inform the physician and obtain an order for monitoring on change sin the skin integrity such as color, size, and pain. The TN stated the skin discoloration could become worse if it was not addressed timely.On September 11, 2025, at 3:15 p.m., an interview was conducted with (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Director of Nursing (DON). The DON stated the purplish skin discoloration on Resident 8's elbow should have been identified on Tuesday, September 9, 2025, and referred to the physician immediately. The DON stated the staff's failure to identify, assess, determine cause and notify physician for treatment orders resulted to a delay in treatment for Resident 8.The facility's policy and procedure titled, SKIN INTEGRITY, dated September 2013, was reviewed. The policy indicated, .The purpose of this procedure is to guide the prevention and treatment of .discolorations .and other skin integrity inssues .to promote healing .General Guidelines .Staff will inspect skin during care, monitor affected area and notify Physician for new skin integrity issue .Documentation .Assess the affected area .Assess for pain and discomfort .Reporting .Report other information in accordance with facility policy/guideline and professional standards of practice .The facility's policy and procedure titled, .Acute Condition Changes-Clinical Protocol, dated march 2018, was reviewed. The policy indicated, .Direct care staff, including nursing assistants will be trained in recognizing subtle but significant changes in the resident (for example .changes in skin color of condition) and how to communicate these changes to the Nurse .Nursing assistants are encouraged to communicate subtle changes in the resident to the nurse .The nursing staff will contact the physician based on the urgency of the situation .The staff and physician will discuss possible causes of the condition change based on factors including resident/patient history, current symptoms, medication regimen, and diagnostic test results .Treatment and Management .The physician will help identify and authorize appropriate treatment .Monitoring and Follow-Up .The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care 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 provide respiratory care and treatment for one resident reviewed for oxygen administration (Resident 4), when the physician's order for oxygen administration was not followed. This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the resident's health condition.Findings:On September 8, 2025, at 11:23 a.m., a concurrent observation and interview was conducted with Resident 4. Resident 4 was observed in bed with oxygen (O2) via nasal cannula (NC - a tube used to deliver oxygen through the nose). Resident 4's oxygen administration was observed at 6 liters per minute (LPM). Resident 4 stated she needed O2 because she was short of breath. Resident 4 stated she had to take off the NC because it was making her nose dry. Resident 4 stated she did not know what rate her O2 should be on.On September 8, 2025, at 11:29 a.m., a concurrent observation, interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 confirmed the O2 level for Resident 4 was at 6 LPM. LVN 1 verified the physician order and stated the O2 level should be between 2 and 4 LPM, as per physician's order. LVN 1 stated the physician's order was not followed.On September 10, 2025, at 8:41 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON confirmed the O2 level should have been between 2-4 LPM, as per physician's order for Resident 4. The DON stated the physician's order was not followed.Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing).The physician's order dated August 27, 2025, indicated, .May use O2 @ 2LPM PRN (as needed) via nasal cannula and titrate up to 4LPM .The facility policy and procedure titled, Oxygen Administration, revised October 2010, was reviewed. The policy indicated, .The purpose of this procedure is to provide guidelines for safe oxygen administration.Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management 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, an assessment was conducted by Licensed Vocational Nurse (LVN) 1, prior to obtaining a pain medication order to treat migraine (severe headache) for one of eight residents reviewed (Resident 35). This failure has the potential to result to inadequate pain management for Resident 35. Findings:On September 9, 2025, at 11:41 a.m., an observation with a concurrent interview was conducted with Resident 35. Resident 35 was in bed, alert, and interviewable. Resident 35 stated she had been requesting to see her physician because she needed to talk to him about her pain medications.On September 9, 2025, Resident 35's record was reviewed. Resident was admitted to the facility on [DATE] with diagnoses including fibromyalgia (condition that causes pain in muscles and soft tissues all over the body).The Physician's Order' dated August 21, 2025, indicated to give Nurtec Oral Disintegrating (brand name medication used to treat migraine) Tablet 75 milligrams (mg- unit of measurement) give one tablet by mouth every 24 hours as needed for migraine prevention.The nursing Progress Notes, documented by Licensed Vocational Nurse (LVN) 1, dated August 21, 2025, indicated, .Resident request for Migraine (sic.). States she use to take it before, MD (Medical Doctor) (Name of MD) made order recd (received) Nurtec Oral Tablet Disintegrating 75 MG Give 1 tablet by mouth every 24 hours for Migraine Prevention. order noted and carried out .The Care Plan dated September 9, 2025, indicated, .At risk for pain or discomfort due to general body .Fibromyalgia, headaches/migraines .Chronic Pain, Migraine.Pain will be relieved to a tolerable level as indicated. Assess for non-verbal indicators of pain .Assess pain every shift and as indicated .Dimmed lighting for photosensitivity .Offer nonpharmacological interventions to relieve discomfort or pain .Notify physician if resident experiences unmanageable or intolerable pain .Offer non pharmacological interventions to relieve discomfort or pain .There was no documented evidence LVN 1 conducted a pain assessment on Resident 35 prior to obtaining the order for Nurtec Oral Tablet Disintegrating 75 MG Give 1 tablet by mouth every 24 hours for Migraine Prevention on August 21, 2025.On September 9, 2025, at 4:35 p.m., an interview was conducted with LVN 1. LVN 1 stated she was the licensed nurse who obtained the order for Nurtec Oral Tablet Disintegrating 75 MG Give 1 tablet by mouth every 24 hours for Migraine Prevention on August 21, 2025. LVN 1 stated: -On August 21, 2025, at 10:53 a.m., Resident 35 asked her if she could get a medication order for her migraine because she was on it before. LVN 1 stated she just told me that.-Resident 35 did not look like she was in pain and complained of migraine at the time she made the request.-She did not conduct a pain assessment before calling the physician and obtained an order for migraine medication as per resident request.-She should have conducted an assessment, checked for the pain level, frequency, and vital signs prior to obtaining a medication order from the physician.On September 11, 2025, at 3:25 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated when a resident complained of pain, the Licensed Nurses (LN) are to assess the resident's pain, offer non-pharmacological interventions, if ineffective, then offer the prescribed pain medication. The DON stated LVN 1 obtaining a medication for migraine without conducting a proper assessment on Resident 35 was not an acceptable standard of practice. The DON stated LVN 1 should have conducted an assessment first, offered non-pharmacological interventions, offered the prescribed pain medication, monitored the resident for 72 hours, and then referred to the physician the complete assessment on Resident 35's complain of migraine, before obtaining an order.The facility's policy and procedure titled, Pain Assessment and Management, dated 2001 was reviewed. The policy indicated, .The purpose of this procedure are to help staff identify pain in the resident, develop interventions consistent with the resident's goals and needs, and address underlying causes of pain .General Guidelines .Pain management is a multidisciplinary process that includes the following .identifying signs and symptoms of and assessing existing pain .recognizing situations and conditions with the potential for pain .identifying the underlying causes, intensity, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	duration, type, and characteristics of pain .addressing the undertluy9ong cause of pain .developing and implementing approaches top pain management based on accepted standards of practice .monitoring effectiveness and interventions .Steps in the Procedure .Recognizing pain .Assessing Pain .Identifying Underlying Causes of Pain .Defining Goals and Appropriate Interventions .Implementing Pain Management Strategies .Monitoring and Modifying Approaches .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when: 1. For two of two residents (Resident 34 and Resident 35), inhalers were not appropriately administered. This failure had the potential for the residents to experience preventable breathing problems and/or other adverse clinical outcomes. 2. One of one opened blood glucose (sugar) test strip vial stored in the medication cart was undated in accordance with the manufacturer's instructions. This failure had the potential for unusable test strips to be used to measure residents' fingerstick blood glucose levels to determine the dose of insulin to be administered. Findings:1a. During a review of Resident 34's HISTORY AND PHYSICAL EXAMINATION [H&P - comprehensive patient assessment], dated March 19, 2025, the H&P indicated a past medical history of COPD [chronic obstructive pulmonary disease - ongoing lung condition]. During a review of Resident 34's medical record, the medical record indicated a physician's orders dated August 27, 2025, for fluticasone-salmeterol (combination of two medications to improve breathing) 250 micrograms / 50 micrograms (mcg - a unit of measurement for dose) diskus (inhalation device). The fluticasone-salmeterol medication order indicated one (1) puff by mouth two times a day. During a review of Resident 34's medical record, the Medication Administration Record (MAR) for August and September 2025 indicated the fluticasone-salmeterol inhalation device was documented as administered twice a day. During a concurrent observation and interview on September 8, 2025, at 3:30 p.m., an inspection of a medication cart was conducted with Registered Nurse 1 (RN 1). When the medication cart was opened, an opened fluticasone-salmeterol inhalation device for Resident 34 was observed stored inside the medication cart. The fluticasone-salmeterol 250 mcg / 50 mcg inhalation device was observed to be undated. The medication carton box for fluticasone-salmeterol inhalation device was labeled 8/27 [August 27, 2025]. The undated fluticasone-salmeterol 250 mcg / 50 mcg inhalation device was observed with 51 puffs remaining out of 60 puffs. RN 1 acknowledged the undated and opened fluticasone-salmeterol inhalation device, the medication carton box dated August 27, 2025, and 51 puffs out of 60 puffs were remaining. During an interview on September 9, 2025, at 2:30 p.m., with RN 1, RN 1 stated the inhaler medication order was routine and not PRN (as needed). RN 1 stated the DON was aware and the facility was investigating. During a concurrent interview and record review on September 11, 2025, at 3:17 p.m., with the Director of Nursing (DON), Resident 34's medical record, medication orders, and MAR were reviewed. The DON stated there should have been approximately 38 puffs remaining on Resident 34's fluticasone-salmeterol 250 mcg / 50 mcg inhalation device when the medication cart was inspected on September 8, 2025. 1b. During a review of Resident 35's History & Physical [H&P], dated August 11, 2025, the H&P indicated a past medical history of COPD. During a review of Resident 35's medical record, the medical record indicated a physician's orders dated December 23, 2024, for albuterol 90 mcg inhaler. The albuterol inhaler medication order indicated two (2) puffs by mouth two times a day. During a review of Resident 35's medical record, the MAR for August and September 2025 indicated the albuterol inhaler was documented as administered twice a day. During a concurrent observation and interview on September 8, 2025, at 3:33 p.m., an inspection of a medication cart was conducted with RN 1. When the medication cart was opened, an opened albuterol 90 mcg inhaler for Resident 35 was observed stored inside the medication cart. The medication carton box for albuterol 90 mcg inhaler was labeled 8/30/25 [August 30, 2025]. The albuterol 90 mcg inhaler was observed with 193 puffs remaining out of 200 puffs. RN 1 acknowledged the albuterol medication carton box dated August 30, 2025, and 193 puffs out of 200 albuterol puffs were remaining. During an interview on September 9, 2025, at 2:30 p.m., with RN 1, RN 1 stated the inhaler medication order was routine and not PRN (as needed). RN 1 stated the DON was aware and the facility was investigating. During a concurrent interview and record review on September 11, 2025, at 3:22 p.m., with the DON, Resident 35's medical record, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication orders, and MAR were reviewed. The DON stated there should have been approximately 168 puffs remaining on Resident 35's albuterol inhaler when the medication cart was inspected on September 8, 2025. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, .4. Medications are administered in accordance with prescriber orders, including any time frame . 2. During a concurrent observation and interview on September 8, 2025, at 3:18 p.m., an inspection of a medication cart was conducted with RN 1 and Licensed Vocational Nurse 1 (LVN 1). An opened and undated blood glucose test strip vial was observed stored in the medication cart. RN 1 and LVN 1stated the opened vial contained 24 test strips remaining out of 50 test strips. LVN 1 stated the vial should have been dated as soon it was opened and stored in the medication cart. During an interview on September 11, 2025, at 3:09 p.m., with the DON, the DON stated their expectation was for everything that was opened to be dated. During a review of the [the name of the test strips manufacturer] insert, dated December 2023, provided by the facility, the manufacturer's insert indicated, .When you first open the vial, write the date on the vial label. Use the test strips within 3 months of first opening the vial.During a review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, dated October 2011, the P&P indicated, .The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level.Steps in the Procedure.2. If using the blood glucose monitoring system (blood glucose meter with test strips), use test strips before their expiration date. Do not use test strips that have been wet, bent or otherwise damaged. For test strips, follow the manufacturer's guidelines.

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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 safe and effective medication labeling and controlled (narcotics) drug storage when: 1. Three of three artificial tears (drug to lubricate dry eyes) medication bottles were not properly labeled with sufficient information to identify the specific resident. This failure had to potential to cause preventable infections from cross-contamination from eye drops were inadvertently mixed up with other residents. 2. The keys to the discontinued controlled substances were stored in an unlocked drawer in the half-opened Director of Nursing (DON) office. This failure had the potential for drug diversion (theft or preventable loss) and impaired (under the influence) staff providing care for a universe of 62 residents. Findings:1. During a concurrent observation and interview on September 8, 2025, at 3:33 p.m., an inspection of a medication cart was conducted with Registered Nurse 1 (RN 1). When the medication cart was opened, three opened carton boxes of artificial tears eye drops (National Drug Code 57896-181-05) were observed stored inside the medication cart. The three artificial tears eye drops indicated the resident's last name on the medication carton box but not on the medication container bottle. RN 1 acknowledged the three residents eye drop cartons were only labeled with the residents last names. RN 1 stated if the unlabeled medications fell outside of the medication cartons, the eye drops could be exchanged with another resident which could result in cross contamination. RN 1 stated the eye drop bottles should have been labeled with two resident identifiers. During an interview on September 11, 2025, at 3:10 PM, with the Director of Nursing (DON), the DON stated the resident's full name should be both on the medication carton and the medication container bottle. The DON acknowledged that one of the resident's last names was misspelled on the medication carton box. During a review of the facility's policy and procedures (P&P) titled, Labeling of Medication Containers, dated April 2019, the P&P indicated, .All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. 2. During an observation on September 8, 2025, at 12:40 p.m., in the DON office, the DON showed where the discontinued controlled substances were stored in the DON office using the narcotic keys. During a concurrent observation and interview on September 11, 2025, at 3:05 p.m., three individuals from the facility's corporate team were observed in the DON office without the DON. The door to the DON office was observed to be half-open. The DON stated the narcotic keys were being stored in an unlocked drawer. The DON stated it was possible that someone might enter the half-opened DON office and use the narcotic key to access the discontinued controlled substances. The DON stated, Maybe I can put a lock on the drawer. During a review of the facility's P&P titled, Storage of Medications, dated November 2020, the P&P indicated, .1.Only persons authorized to prepare and administer medications have access to locked medications . During a review of the facility's P&P titled, Controlled Substances, dated November 2022, the P&P indicated, .13. Controlled substances remaining the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure nutrition services were provided for two of three residents (Resident 22 and Resident 26) reviewed, when:1.Resident 22, dietary preferences were not met; and2.Resident 26 annual (yearly) nutritional assessment had not been conducted.These failures had the potential for Resident 22 and Resident 26 to have inadequate dietary intake because reasonable efforts were not made to accommodate Resident 22's food preferences and Resident 26's annual nutritional assessment were not performed.Findings:1.On September 8, 2025, at 9:34 a.m., Resident 26 was observed sitting up in bed alert and oriented. During a concurrent interview with Resident 26, she stated the facility food is a mushy mess and did not receive what is on the menu. Resident 26 further stated if she did not like what is on the menu she ordered her own food. One box of Cheerios cereal and a case of cup of noodles soup was observed stored on Resident 26's closet.On September 8, 2025, at 12:23 p.m., Resident 26 was observed sitting up in bed eating lunch. During a concurrent interview with Resident 26, she stated the roast beef was full of fat, the brussels sprouts were over cooked, and that she could not eat the food and requested an alternate meal. Resident 26 meal ticket indicated Regular Consistent Controlled Carbohydrate Diet (diet to stabilize blood sugar), thin liquids, add extra oz (ounce) of meat or entree. Resident 26 lunch tray consisted of cooked sprouts, mashed potatoes, roast beef with gravy, side salad, chocolate ice cream, fruit juice and water.On September 8, 2025, Resident 26's medical record was reviewed.The admission record indicated Resident 26 was admitted to the facility on [DATE], with diagnoses which included fibromyalgia (widespread body pain), osteoarthritis (stiffness and swelling of joints), hypertension (high blood pressure), and diabetes mellitus (high blood sugar).The history and physical completed on August 6, 2025, indicated Resident 26 had the capacity to make informed decisions.The annual nutritional assessment dated [DATE], indicated Resident 26's diet preferences and nutritional needs. There was no documented evidence that an annual nutritional assessment was conducted for Resident 26 to update her nutritional needs and preferences.2.On September 8, 2025, at 12:32 p.m., Resident 22 was observed sitting on the side of her bed eating lunch. During a concurrent interview with Resident 22, she stated she had received cooked vegetables again instead of raw vegetables. Resident 22's meal ticket and lunch tray was observed. Resident 22's meal ticket indicated preference of raw vegetables and Resident 22's lunch tray consisted of cooked sprouts, mashed potatoes, roast beef with gravy, side salad, chocolate ice cream, coffee and milk. Resident 22 further stated she could not eat the side salad because of the red chopped bell peppers which she dislikes.On September 8, 2025, Resident 22's medical record was reviewed.The admission record indicated Resident 22 was admitted to the facility on [DATE], with diagnoses which included dementia (memory impairment), hypertension (high blood pressure) and hyperlipidemia (high cholesterol).The history and physical completed on July 18, 2025, indicated Resident 22 was unable to make informed medical decisions. The dietary order dated September 3, 2025, indicated .No added salt diet.regular texture.thin consistency.patient request no red or green peppers.The care plan dated May 21, 2025, indicated .Focus.resident is at risk for malnutrition due to.mechanically altered diet.poor intake.Intervention.cater to food preferences.refer to RD as needed.On September 10, 2025, at 2:45 p.m., a concurrent interview and record review was conducted with the Dietary Supervisor (DS). The DS stated the DS manages resident dietary needs and preferences through quarterly interviews. The RD then conducts annual assessments to coordinate each resident's dietary care plan. The DS reviewed Resident 22 medical record and stated Resident 22's preference was raw vegetables and dislikes are red and green bell peppers. The DS reviewed a picture of Resident 22's meal ticket and lunch tray and stated the expectations of dietary are residents receive their dietary preferences. The DS stated Resident 22's should have received her preference of raw vegetables.The DS reviewed (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	3476 W. Wilson St. Banning, CA 92220

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 26's medical record and stated Resident 26's last annual nutritional assessment was conducted on April 17, 2024. The DS stated there was no documented evidence Resident 26's annual nutritional assessment was conducted. The DS stated Resident 26 should have had an annual nutritional assessment. The DS further stated potential outcomes of residents not receiving their dietary preferences and annual nutritional assessment could result in undesired weight loss.A review of the policy and procedure titled Resident Food Preferences, dated 2001, indicated .Upon the resident's admission, staff will identify a resident's food preference.If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with.A review of the facility policy and procedure titled Comprehensive Assessments, dated 2001, indicated .annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis at least every 366 days.

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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 expired food items were not stored in the refrigerator, readily available for use. This failure had the potential to result in foodborne illness to a vulnerable facility population.Findings:On September 8, 2025, at 8:50 a.m., during the initial tour of the kitchen, an observation and concurrent interview was conducted with the Dietary Supervisor (DS) and the Dietary Aide (DA). One prune juice carton labeled with a use-by- date of August 30, 2025, was observed in the refrigerator, readily available for use. The DA stated the August 30, 2025 date was the date when the juice carton was opened, and it should have been discarded five days after the open date. In a concurrent interview, the DS stated the date of August 30, 2025 was the date when the prune juice was opened and once opened, it was good for five days. The DS stated the prune juice should have been discarded and not stored in the refrigerator passed the use-by-date.The facility policy and procedure, titled, Dry Goods Storage Guidelines, dated 2023, was reviewed. The policy and procedure indicated, .Juices, fruit.Opened-Refrigerated .5 days .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 infection control measures were followed and implemented when two employees from a consulting doctor's office did not follow an Enhanced Barrier Precautions (EBP - infection control intervention designed to reduce transmission of resistant organisms that required use of gown and glove during high contact resident care activities) for one of five residents reviewed (Resident 59).This failure had the potential to increase the spread of pathogens (germs) and infections by staff to the residents. Findings:On September 9, 2025, at 10:49 a.m. an observation was conducted on Resident 59's room. Observed outside Resident 59's room was a sign indicating Resident 59 and his room mate were both on EBP. PPE (Protective Personal Equipment - items of protective clothing or equipment designed to guard against health and safety hazards, e.g. mask, gown, gloves) supplies, including gown, mask, and gloves were observed stored by the door. The EBP sign by the door indicated, .Enhanced Barrier Precautions .Room Bed A and Bed B .Caring for devices and giving medical treatments .Inside the room, Resident 59 was observed in bed, alert, with his upper body half exposed. Cardiac Sonographer (CS) 2 was observed seated on a chair about less than two to three feet away from Resident 59's bed. CS 1 was observed standing next to her. Both employees were observed wearing gloves but did not have a gown on. A medical equipment was observed next to Resident 59. CS 2 stated they were doing an ultrasound (non-invasive medical procedure using a machine that detects images of internal organs or tissues) on Resident 59.On September 9, 2025, at 11:05 a.m., an observation with a concurrent interview was conducted with CS 1 and 2. CS 2 was observed coming out from Resident 59's room, while CS 1 fixed and/or moved Resident 59's bed before coming out of the room. In a concurrent interview, CS 1 stated they were employees from the cardiologist's (a doctor who specializes in heart medical conditions) office and they did an ECG (electrocardiogram- non-invasive test that measures the heart's electrical activity through electrodes {sensors used in ECG} applied on the chest) on Resident 59. CS 1 stated they started conducting the ECG at 9:50 a.m.CS 2 was asked about the EBP sign by Resident 59's door. CS 2 stated they thought the EBP was for Resident 59's roommate. CS 2 stated none of the facility staff informed them on the EBP required for Resident 59. CS 2 stated both her and CS 1 only used gloves during the ECG test. CS 2 stated both she and CS 1 should have worn mask, gown, and gloves when they did the ECG test on Resident 59.On September 9, 2025, at 2:41 p.m., an interview was conducted with Infection Prevention Nurse (IPN). The IPN stated Resident 59 was on EBP because he had a foley catheter (thin, flexible tube inserted into the bladder to drain urine). The IPN stated Resident 59 was on EBP to help prevent him from getting infection from other people because he was prone to infection. The IPN stated the EBP was also a protection from infection for the staff as well. The IPN stated the staff should wear gown, glove, and mask, when providing patient care. The IPN stated CS 1 and 2 should have followed and implemented the proper EBP when they entered Resident 59's room to do the ECG test. The IPN stated CS 1 and 2 came from outside and they are coming here, they can give infection, to Resident 59.On September 9, 2025, Resident 9's record was reviewed. Resident 9 was admitted to the facility on [DATE], with diagnoses including neuromuscular dysfunction of the bladder (condition where the nerves and muscles that control bladder are impaired).The Physician's Order, dated July 21, 2025, indicated, .Enhanced Barrier Precaution during high contact resident care activities secondary to due to indwelling foley catheter .The Care Plan, dated, May 16, 2025, indicated, .Enhanced Barrier Precautions: Resident requires enhanced barrier precautions during high-contact resident care activities due to the presence of: indwelling device .urinary catheter .Goal .Enhanced barrier precautions will be appropriately utilized to reduce the risk of transmission of multidrug-resistant organisms .Interventions/Tasks .Utilize PPE (gown and gloves .during high contact resident care activities) .The facility's policy and procedure, titled, Enhanced Barrier Precautions, dated March (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2024 was reviewed. The policy indicated .Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the transmission of multi-drug resistant organisms (MDROs) to the residents .EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities .gloves and gown are applied prior to performing the high contact resident care activity .Residents, families, and visitors ARE Notified of the implementation of EBPs throughout the facility .