STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviara Healthcare Center	944 Regal Road Encinitas, CA 92024

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Advance Directive information was provided to 13 of 27 sampled residents (Resident 2, 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74, 94). This failure had the result for Resident 2, 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74 and 94 to not have the opportunity to express wishes for care if capacity for decision making was lost.Findings: 1. On 9/16/25 Resident 7's clinical record was reviewed. Resident 7 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 2/20/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 7 with Advance Directive information. On 9/16/25 Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 8 with Advance Directive information. On 9/16/25 Resident 12's clinical record was reviewed. Resident 12 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 10/10/24 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 12 with Advance Directive information. On 9/16/25 Resident 14's clinical record was reviewed. Resident 14 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated Resident 14 had an Advance Directive. A copy of Resident 14's Advance Directive was not in the clinical record. On 9/16/25 Resident 15's clinical record was reviewed. Resident 15 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 6/11/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 15 with Advance Directive information. On 9/16/25 Resident 94's clinical record was reviewed. Resident 94 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment (POLST) dated 7/3/25 was reviewed. Section D Advance Directives information had a box checked that indicated Resident 14 had an Advance Directive. A copy of Resident 14's Advance Directive was not in the clinical record. On 9/17/25 at 4:45 P.M., an interview and record review was conducted with Licensed Nurse (LN 21). LN 21 stated she was the admission nurse during the PM shift. LN 21 stated she would have the resident or representative party fill out the POLST and would ask new admission if they have or wanted an Advance Directive. LN 2 stated if the resident wanted an advanced directive, the resident would be referred to the Social Worker to follow up. LN 21 stated if the new admission refused, she would not document that. LN 21 stated I guess I should document it. 2. On 9/16/25 Resident 6's clinical record was reviewed. Resident 6 was re-admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 12/9/19 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 6 with Advance Directive information. On 9/16/25 Resident 13's clinical record was reviewed. Resident 13 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 8/25/15 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 13 with Advance Directive information. On 9/16/25 Resident 18's clinical record was reviewed. Resident 18 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 7/7/25 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 18 with Advance Directive information. On 9/16/25 Resident 22's clinical record was reviewed. Resident 22 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 9/8/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 22's Legally Recognized Decisionmaker with Advance Directive information. On 9/16/25 Resident 24's clinical record was reviewed. Resident 24 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 24 with Advance Directive information. On 9/16/25 Resident 79's clinical record was reviewed. Resident 79 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 8/11/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 79 with Advance Directive information. On 9/16/25 Resident 94's clinical record was reviewed. Resident 94 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment (POLST) dated 8/11/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 94 with Advance Directive information. On 9/16/2025 at 2:57 P.M., an interview was conducted with the Social Worker Director (SWD). The SWD stated if the resident did not bring in an Advance Directive, the family or representative was contacted to obtain one. The SWD stated the Advance Directive or POLST was asked for as soon as possible after admission. The SWD stated if the resident was their own responsible party, the POLST is usually obtained as soon as possible after admission. The SWD stated if the resident wanted information on an Advance Directive, the facility would start the process. The SWD stated the paperwork would have been printed and filled out on the county website. The SWD stated there was no documentation that Advance Directive information was provided to the residents, family and/or representative for Residents 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74, 94. On 9/18/2025 at 2:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that a POLST is not the same as an Advance Directive. The DON stated her expectation was that there would have been documentation in the medical record that an Advance Directive was offered or refused by the resident, the resident's family, and/or representative. The DON stated that a copy of any advanced directive should have been uploaded into the clinical record. A review of the facility's policy titled Advance Directive dated September 2022 indicated, .h.A POLST paradigm form is not an advance directive.Determining Existence of Advance Directive .The resident or representative is provided with written information .to formulate an advance directive . If the Resident Does not have an Advance Directive . 1.the facility staff will offer assistance in establishing advance directives. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.If the Resident Has an Advance Directive.1. copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 3.placing the advance directive documents in a prominent, accessible location in the medical record. 3. Resident 2 was admitted to the facility on [DATE] with a diagnosis that included congested heart failure (CHF- a condition when the heart is unable to pump blood as effectively as it should) per the facility's admission record. On 9/17/25 at 9:47 A.M., Resident 2's clinical record was reviewed. Resident 2's Physician Orders for Life-Sustaining Treatment (POLST- a portable document with actionable medical orders for seriously ill or frail people that specify their preferences for life-sustaining), dated 7/30/25, indicated that Resident 2 did not have an Advanced Directive. Further review of Resident 2's clinical record indicated that the facility did not provide Resident 2 with information on Advanced Directives. On 9/18/2025 at 2:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that a POLST is not the same as an Advance Directive. The DON stated her expectation was that there would have been documentation in the medical record that an Advance Directive was offered or refused by the resident, the resident's family, and/or representative. A review of the facility's policy titled Advance Directive dated September 2022 indicated, .h.A POLST paradigm form is not an advance directive.Determining Existence of Advance Directive .The resident or representative is provided with written information .to formulate an advance directive . If the Resident Does not have an Advance Directive . 1.the facility staff will offer assistance in establishing (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	advance directives. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.If the Resident Has an Advance Directive.1. copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 3.placing the advance directive documents in a prominent, accessible location in the medical record.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to identify a system wide issue identified by the survey team for not providing Advanced Directive information for 13 of 27 sampled residents (Resident 2, 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74, 94). This failure had the result for Resident 2, 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74 and 94 to not have the opportunity to express wishes for care if capacity for decision making was lost.On 9/16/25 Resident 7's clinical record was reviewed. Resident 7 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 2/20/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 7 with Advance Directive information.On 9/16/25 Resident 8's clinical record was reviewed. Resident 8 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 8 with Advance Directive information.On 9/16/25 Resident 12's clinical record was reviewed. Resident 12 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 10/10/24 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 12 with Advance Directive information.On 9/16/25 Resident 14's clinical record was reviewed. Resident 14 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated Resident 14 had an Advance Directive. A copy of Resident 14's Advance Directive was not in the clinical record.On 9/16/25 Resident 15's clinical record was reviewed. Resident 15 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 6/11/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 15 with Advance Directive information.On 9/16/25 Resident 94's clinical record was reviewed. Resident 94 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 7/3/25 was reviewed. Section D Advance Directives information had a box checked that indicated Resident 14 had an Advance Directive. A copy of Resident 14's Advance Directive was not in the clinical record.On 9/16/25 Resident 6's clinical record was reviewed. Resident 6 was re-admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 12/9/19 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 6 with Advance Directive information. On 9/16/25 Resident 13's clinical record was reviewed. Resident 13 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 8/25/15 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 13 with Advance Directive information. On 9/16/25 Resident 18's clinical record was reviewed. Resident 18 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 7/7/25 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 18 with Advance Directive information.On 9/16/25 Resident 22's clinical record was reviewed. Resident 22 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 9/8/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Directive. There was no documentation that the facility provided Resident 22's Legally Recognized Decisionmaker with Advance Directive information. On 9/16/25 Resident 24's clinical record was reviewed. Resident 24 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 5/13/25 was reviewed. Section D Advance Directives information had a box checked that indicated No Advance Directive. There was no documentation that the facility provided Resident 24 with Advance Directive information. On 9/16/25 Resident 79's clinical record was reviewed. Resident 79 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 8/11/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 79 with Advance Directive information. On 9/16/25 Resident 94's clinical record was reviewed. Resident 94 was admitted to the facility on [DATE] per the facility's admission Record. A document titled Physician Orders for Life-Sustaining Treatment (POLST) dated 8/11/23 was reviewed. Section D Advance Directives information was blank. There was no documentation that the facility provided Resident 94 with Advance Directive information. On 9/16/2025 at 2:57 P.M., an interview was conducted with the Social Worker Director (SWD). The SWD stated if the resident did not bring in an Advance Directive, the family or representative was contacted to obtain one. The SWD stated the Advance Directive or POLST was asked for as soon as possible after admission. The SWD stated if the resident was their own responsible party, the POLST is usually obtained as soon as possible after admission. The SWD stated if the resident wanted information on an Advance Directive, the facility would start the process. The SWD stated the paperwork would have been printed and filled out on the county website. The SWD stated there was no documentation that Advance Directive information was provided to the residents, family and/or representatives for Residents 6, 7, 8, 12, 13, 14, 15, 18, 22, 24, 74, 94. On 9/17/25 Resident 2's clinical record was reviewed. Resident 2 was admitted to the facility on [DATE] with a diagnosis that included congested heart failure (CHF- a condition when the heart is unable to pump blood as effectively as it should) per the facility's admission record. Resident 2's POLST, dated 7/30/25, indicated that Resident 2 did not have an Advanced Directive. Further review of Resident 2's clinical record indicated that the facility did not provide Resident 2 with information on Advanced Directives. On 9/18/2025 at 2:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that a POLST is not the same as an Advance Directive. The DON stated her expectation was that there would have been documentation in the medical record that an Advance Directive was offered or refused by the resident, the resident's family, and/or representative. The DON stated that a copy of any advanced directive should have been uploaded into the clinical record. On 9/18/2025 at 3:00 P.M., the facility Administrator and DON presented their QAPI program to the survey team. The DON stated that they failed to identify Advanced Directives not being offered or documented by staff being offered. The DON stated it is her expectation that all residents be given information about Advanced Directives and that they have now initiated this issue into their current QAPI.A review of the facility's policy titled Advance Directive dated September 2022 indicated, .h.A POLST paradigm form is not an advance directive.Determining Existence of Advance Directive .The resident or representative is provided with written information .to formulate an advance directive . If the Resident Does not have an Advance Directive . 1.the facility staff will offer assistance in establishing advance directives. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance.If the Resident Has an Advance Directive.1. copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. 3.placing the advance directive documents in a prominent, accessible location in the medical record.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the facility's policy and procedure for infection control were implemented for seven of seven residents (103,15,113,82,10,140, 4), when:1. Resident 103 was not tested for Covid-19 after exposure to a positive roommate according to facility policy. 2. Licensed Nurse (LN) 35 did not use a precaution gown when administering medications via gastrostomy tube (G-tube, a tube is inserted into the stomach to provide medications and nutrients) to Resident 15 on Enhanced Barrier Precautions (EBP, a precaution that requires usage of gowns and gloves during specific, high-contact care activities).3. LN 36 used her own personal blood pressure device (BP, a fabric blood pressure machine that cannot be properly sanitized) on two residents (Resident 113, 82) and did not clean the BP cuff in between the residents' use.4. LN 37 did not perform hand hygiene in between glove changes when administering medications to Resident 10.5. LN 39 applied gloves at the start of medication administration, using the same pair of gloves, touched items on the bedside tray and then administered eye ointment to Resident 140.6. LN 38 dropped a nebulizer piece (a machine that delivers inhaled medicated steam to the lungs) on the floor of Resident 4's EBP room and used the same piece for the nebulizing treatment. In addition, LN 38's precaution gown was not secured while in Resident 4's EBP room performing care.These failures had the potential to spread infection amongst the residents, staff, and visitors.Findings: 1. On 9/17/25 at 10:01 A.M., an interview and record review was conducted with Infection Preventionist Nurse (IP). The Infection Preventionist Consultant (IPC) was also present. The IP reviewed Resident 132's clinical record. The IP stated Resident 132 was sent out to the hospital on 9/10/25 for hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). The IP stated the facility had received an update from the hospital that Resident 132 tested positive for Covid-19. The IP stated Resident 132 returned to facility on 9/12/25 and returned to his room for a 10-day isolation. The IP reviewed Resident 103's clinical record. The IP stated Resident 103 (Resident 132's roommate), was asymptomatic and tested for Covid-19 on 9/10/25 with negative results. The IP stated Resident 103 was moved out of the room on 9/15/25. The IP and IPC stated Resident 103 should have been tested two more times on 9/12/25 and 9/14/25 and was not and he should have been. The IP and IPC stated it was important to test for Covid-19 to stop the spread of infection. On 9/18/25 at 2:39 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated the importance of testing for exposed Covid-19 residents was to prevent an outbreak and start isolation and treatment. The DON stated her expectations for Resident 103 Covid-19 testing should have been done on day 1, day 3 and day 5. A review of facility policy titled Coronavirus Disease Reporting & Management, Testing & Vaccination, dated February 2022, indicated, .6. All Health Care Providers (HCP) who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested promptly . if negative, again 5-7 days after the exposure. 2. A review of Resident 15's admission record indicated the resident was admitted to the facility on [DATE] with a diagnosis of infection and inflammatory reaction due to indwelling urethral catheter (a tube inserted into the bladder to drain urine) and gastrostomy status (G-tube). A review of Resident 15's physician orders indicated an order for enhanced barrier precautions during high contact resident care activities started on 7/2/25. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/25 at 8:37 A.M., an observation of Resident 15's medication administration was conducted with LN 35. An EBP sign was observed on the outside of Resident 15's door that stated .when providing high contact care.staff must: clean hands, wear gown, wear gloves. Outside of Resident 15's door, LN 35 applied a pair of gloves but did not put on a precaution gown and entered Resident 15's room. LN 35 began the process to administer Resident 15's medication through his G-tube and did not wear a precaution gown. LN 35 finished administering Resident 15's medications, took off and threw away her gloves, performed hand hygiene and exited the room. On 9/15/25 at 12:44 P.M., an interview was conducted with LN 35. LN 35 stated she did not wear a precaution gown while administering Resident 15's medications and she should have. LN 35 stated when providing care to residents that are on EBP, staff must wear a gown and gloves to protect the resident and others from germs. 3. A review of Resident 113's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of immunodeficiency due to drugs. A review of Resident 82's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of candidal stomatitis (a fungal infection of the mouth caused by the Candida albicans fungus). A review of Resident 82's physician orders indicated an order for Enhanced barrier precautions during high contact resident care activities starting on 7/25/25. On 9/15/25 at 9:05 A.M., an observation of Resident 113 and Resident 82's medication administration was conducted with LN 36. LN 36 was observed taking a personal BP device out of the top drawer of the medication cart. The personal BP device had a blue, soft fabric wrapped around both sides of the BP cuff. An EBP sign was observed outside of the door of Resident 113 and Resident 82 and LN 36 entered the room. LN 36 applied the personal BP device to the left wrist of Resident 113. After taking the blood pressure of Resident 113, LN 36 removed the personal BP device and did not clean it. LN 36 then applied the same personal BP device to the left wrist of Resident 82 to take his blood pressure. LN 36 exited the resident's (Resident 113, 82) room and placed the BP device on the medication cart. On 9/15/25 at 11:53 A.M., an interview was conducted with LN 36. LN 36 confirmed she used the personal BP device on the residents (Resident 113, 82) and stated she had brought the device from home. LN 36 confirmed the personal BP device cuff had a fabric that could not have been properly sanitized. LN 36 stated she had access to the facility's portable BP machine and should have used that instead to take the resident's (Resident 113, 82) blood pressure because that machine was able to be properly sanitized. LN 36 stated the residents (Resident 113, 82) could have been put at risk for contracting infections by usage of the personal BP device. 4. A review of Resident 10's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of immunodeficiency. On 9/15/25 at 9:43 A.M., an observation of Resident 10's medication administration was conducted with LN 37. LN 37 was observed applying a pair of gloves before entering Resident 10's room. LN 37 exited Resident 10's room to grab an item from the medication cart. LN 37 took off the pair of gloves, placed them into the trash, and retrieved the item from the medication cart. LN 37 was observed applying a new pair of gloves without performing hand hygiene. LN 37 entered Resident 10's room wearing the same pair of gloves and continued providing care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/15/25 at 12:30 P.M., an interview was conducted with LN 37. LN 37 stated he did not perform hand hygiene after glove changes upon exiting Resident 10's room. LN 37 stated he should have performed hand hygiene before applying a new pair of gloves and entering Resident 10's room. LN 37 stated it was important to perform hand hygiene properly to protect the residents from getting infections. 5. A review of Resident 140's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of unspecified blepharitis left lower eyelid (inflammation of the eyelid generally caused by bacterial overgrowth) and cellulitis (bacterial infection of the skin) of the back. A review of Resident 140's physician orders indicated an order on 9/13/25 for Erythromycin Ophthalmic Ointment (antibiotic ointment for the eye) instill 1 strip in left eye for 10 days. On 9/16/25 at 8:30 A.M., an observation of Resident 140's medication administration was conducted with LN 39. LN 39 was observed applying a pair of gloves and entered Resident 140's room. LN 39 administered Resident 140 his oral medications and picked up items on his tray table wearing the same pair of gloves. LN 39 then applied the Erythromycin Ophthalmic Ointment to Resident 140's left eye wearing the same pair of gloves. LN 39 removed the pair of gloves, placed them into the trash, performed hand hygiene and exited Resident 140's room. On 9/16/25 at 2:49 P.M., an interview was conducted with LN 39. LN 39 stated she did not change her gloves or perform hand hygiene prior to applying the Erythromycin Ophthalmic Ointment to Resident 140 and she should have. LN 39 stated hand hygiene and glove changes are performed to protect the residents from getting bacteria and infections. 6. A review of Resident 4's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of mild intermittent asthma (a condition that causes inflammation of the lungs making it difficult to breath) and immunodeficiency. A review of Resident 4's physician orders indicate an order on 9/8/25 for Ipratropium-Albuterol Solution inhale orally every 6 hours for SOB (shortness of breath). On 9/17/25 at 8:25 A.M., an observation of Resident 4's medication administration was conducted with LN 38. An EBP sign was observed on the outside of Resident 4's door. LN 38 put on a precaution gown without tying the back strings of the gown, put on a pair of gloves, and entered Resident 4's room. LN 38's precaution gown was observed falling off her shoulders and LN 38 used her gloved hands to pull it back up. LN 38 prepared Resident 4's bedside table to administer the prescribed nebulizing treatment. LN 38 began to assemble the nebulizer pieces and dropped a piece on the floor of Resident 4's room. LN 38 kneeled on the floor and picked up the nebulizer piece. LN 38 went into Resident 4's bathroom to rinse the nebulizer piece. LN 38 then assembled the pieces, including the piece that dropped on the floor and began administering Resident 4's nebulizing treatment. After Resident 4's treatment concluded, LN 38 instructed the resident to lean forward so she could listen to his lungs. LN 38's precaution gown was observed off her shoulders, leaving her scrub top exposed. Resident 4 leaned forward and placed his hand on LN 38's left shoulder, directly on her scrub top. LN 38 finished Resident 4's nebulizing treatment and took off her precaution gown and gloves and placed them into the trash. LN 38 performed hand hygiene and exited Resident 4's room. On 9/17/25 at 11:20 A.M., an interview was conducted with LN 38. LN 38 stated her precaution gown was not secured prior to entering Resident 4's room. LN 38 stated she should have obtained a new (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precaution gown and ensured it was tied before entering Resident 4's room. LN 38 confirmed that she had dropped the nebulizer piece on the floor of Resident 4's EBP room and used it for the resident's breathing treatment. LN 38 stated she should have disposed of the dropped nebulizer piece and obtained a new one to administer Resident 4's nebulizer treatment. On 9/18/25 at 10:42 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated LN 35 should have used a precaution gown when administering medication via G-tube to Resident 15 to protect the resident and others from acquiring infections. The DON stated she was unaware that LN 36 was using a personal BP device to take residents' blood pressure. The DON stated, that is not okay and LN 36 should be using the facility provided BP equipment for the residents. The DON stated the personal BP device could not be properly sanitized and was not safe for resident use. The DON stated that nurses should always maintain appropriate infection control practices by performing consistent hand hygiene and glove changing. The DON further stated hand hygiene should be performed directly before administering eye treatments or medications. The DON stated the residents (Resident 37, 39) could have been exposed to bacteria and acquired infections. The DON stated LN 38 should have ensured her precaution gown was tied and secured prior to entering Resident 4's room. The DON stated it was not acceptable that LN 38 used the nebulizer piece that fell on the room floor for Resident 4's nebulizer treatment. The DON stated LN 38 should have discarded the nebulizer piece that fell on the floor and should have used a new nebulizer piece to administer Resident 4's nebulizer treatment. A review of the facility's policy titled Infection Prevention and Control Program, revised April 2025, indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.7. Prevention of Infection.educating staff and ensuring that they adhere to proper techniques and procedures.implementing appropriate enhanced barrier and transmission based precautions when necessary. A review of the facility's policy titled Enhanced Barrier Precautions, revised December 2024, indicated, .7. EBP's employ targeted gown and glove use in addition to standard precautions during high contact resident care activities.8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include:.with residents clothing or skin.device care or use.feeding tube. A review of the facility's policy titled Handwashing/ Hand Hygiene, revised October 2023, indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections.5. The use of gloves does not replace hand washing/hand hygiene. A review of the facility's policy titled Medication Administration Eye Drops, dated 1/23, indicated, .to administer ophthalmic solution into eye in a safe and accurate manner.Perform hand hygiene.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure informed consent was obtained prior to administering psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) for one of 24 sampled residents (Resident 67). This failure resulted in Resident 67 not informed of the potential adverse consequences associated with the use of these psychotropic medications which could be detrimental to the resident's well-being prior to administration. A review of Resident 67's admission record initiated on 9/16/25, indicated resident was admitted on [DATE] for rehabilitation therapy, physical and occupational therapy with medical history including bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania (high energy and euphoria) and depression (low mood and lethargy), depression (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once pleasurable) & dementia (a general term for a group of brain disorders that cause a progressive decline in cognitive abilities, including: Memory, Thinking, Language, Orientation, Judgment, and Problem-solving skills). A review of Resident 67's order summary report showed mirtazapine 30 milligram (mg) tablet by mouth one time a day for depression, oxcarbazepine 300 mg tablet by mouth two times a day for bipolar disorder and risperidone 1 mg by mouth in the morning for bipolar disorder ordered on 7/23/25. Further review of Resident 67's medical record showed informed consent for oxcarbazepine, mirtazapine and risperidone was documented by licensed nurse (LN) on 7/28/25 and signed by physician on 7/29/25. Review of Resident 67's July 2025 medication administration record indicated the administration of oxcarbazepine, mirtazapine and risperidone was initiated on 7/24/25. During a concurrent interview and record review with LN 41 on 9/17/25 at 1:00 P.M., LN 41 verified psychotropic informed consent was documented on 7/28/25 and signed by the prescriber on 7/29/25. During a concurrent interview and record review with the DON on 9/17/25 at 4:10 P.M., the DON stated there should be documented informed consent for each psychotropic medication prior to administration. The DON verified the administration of the psychotropic medications was started on 7/24/25, and the documented informed consent signed by the prescriber was dated 7/29/25. A review of facility's policy titled Psychoactive/Psychotropic Medication Use revised April 2025, indicated . 3. A. i. The resident or resident representative has the right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. iii Prior to administration of psychotropic medication, the prescribing clinician will obtain informed consent from the resident (or as appropriate, the resident representative) and document the consent in the medical record. Iv. A licensed nurse must verify informed consent has been obtained from the resident or resident representative prior to administering psychotropic medication.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide and protect privacy for one resident (Resident 15) during medication administration.This failure had the potential to negatively affect Resident 15's feelings of self-worth and self-esteem.Findings:A review of Resident 15's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of unspecified dementia (a condition that affects mental cognition and memory), aphasia (difficulty understanding or producing speech), dysphagia (difficulty swallowing), and gastrostomy status (a tube inserted into the gastrointestinal tract to provide nutrition and medications).A review of Resident 15's physician orders indicate active orders for .NPO [nothing by mouth] diet.Enteral [tube inserted into stomach] Feed Order. May Crush Medications Unless Contraindicated.On 9/15/25 at 8:37 A.M., an observation and interview was conducted with Licensed Nurse (LN) 35 during Resident 15's medication administration. LN 35 entered Resident 15's room. Resident 15 was observed lying in bed with the bed sheet pulled down and hospital gown pulled up exposing his stomach and adult brief. LN 35 began the process to administer Resident 15's medication through his gastrostomy tube (G-tube). Resident 15's privacy curtain was not pulled closed by LN 35 and the room door remained open. Resident 15 was observed attempting to pull down his hospital gown and covering his brief. LN 35 completed Resident 15's medication administration and left the room.On 9/15/25 at 12:44 P.M., an interview was conducted with LN 35. LN 35 stated she did not close the door or pull the curtain when she was administering medications to Resident 15. LN 35 stated she should have pulled the curtain to protect Resident 15's privacy during medication administration. LN 35 confirmed she did not adjust Resident 15's gown and sheet and she should have. LN 35 further stated she would have felt embarrassed and ashamed if she was exposed during medication administration.On 9/18/25 at 10:42 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated LN 35 should have ensured the privacy curtain was pulled for Resident 15 before beginning medication administration and should have ensured the resident was covered prior to providing care. The DON stated residents' privacy must be always maintained. A review of the facility's policy titled Dignity, revised February 2021, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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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 out of 24 sampled residents (Residents 67) was free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when: 1. Nonpharmacological intervention was not implemented; side effects and behaviors were not monitored for Resident 67's risperidone & oxcarbazepine.2. Resident 67's psychotropic medications were not evaluated on admission for potential dose reduction or discontinuation. These failures resulted in unnecessary psychotropic medications for Resident 67, which had the potential for increased risks associated with psychotropic medication use that include but not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, abnormal involuntary movements, and memory loss. A review of Resident 67's admission record initiated on 9/16/25, indicated resident was admitted on [DATE] for rehabilitation therapy, physical and occupational therapy with medical history including bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania (high energy and euphoria) and depression (low mood and lethargy), depression (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once pleasurable) & dementia (a general term for a group of brain disorders that cause a progressive decline in cognitive abilities, including: Memory, Thinking, Language, Orientation, Judgment, and Problem-solving skills). A review of Resident 67's order summary report showed mirtazapine 30 milligram (mg) tablet by mouth one time a day for depression, oxcarbazepine 300 mg tablet by mouth two times a day for bipolar disorder and risperidone 1 mg by mouth in the morning for bipolar disorder ordered on 7/23/25. 1. Further review of Resident 67's medical record showed specific behaviors manifested were not identified and documented for oxcarbazepine and risperidone's use. Review of Resident 67's order summary report and the medication administration record (MAR) did not show behavior and side effects (including high blood sugar, orthostatic hypotension - sudden drop in blood pressure upon standing, and involuntary movement disorder) monitoring for oxcarbazepine and risperidone. Review of Resident 67 medical record also showed abnormal involuntary movement scale tests (AIMS, a rating scale used to detect and monitor tardive dyskinesia - a disorder involving involuntary, rhythmic dance-like movements of the face, mouth, trunk, and limbs, which can be a side effect of long-term antipsychotic medication) were not performed for Resident 67. 2. Further Resident 67 medical record review showed there was no admission assessment/evaluation of mirtazapine, oxcarbazepine and risperidone to determine whether to be reduced or discontinued. On 9/17/25 at 12:14 P.M., during an interview, licensed nurse (LN) 41 stated Nurse Practitioner (NP) 42 was the psychiatry provider. On 9/17/25 at 12:39 P.M., an interview was conducted with nurse practitioner (NP) 42 regarding Resident 67's psychotropic medications. NP 42 stated he had not been consulted for Resident 67. NP 42 stated the other psychiatry nurse practitioner may have been consulted. During a concurrent interview and record review with LN 41 on 9/17/25 at 1:00 P.M., LN 41 could not find any psychiatry provider notes for Resident 67. LN 41 verified there was no behavior & no side effects monitoring for Resident 67's risperidone & Oxcarbazepine. LN 41 also verified resident specific non-pharmacological intervention for the behaviors manifested for risperidone & oxcarbazepine use were not implemented and monthly psychotropic summary report for providers was not documented for Resident 67. On 9/17/25 at 3:50 P.M., during an interview, the Director of Nursing (DON) stated the facility's consultant pharmacist was on vacation. During a concurrent interview and record review with the DON on 9/17/25 at 4:10 P.M., the DON verified Resident 67 have not been seen by any psychiatry provider and psychotropic medications have not been evaluated. The DON also verified there was no behavior & no side effects monitored, and no non-pharmacological intervention implemented for risperidone & Oxcarbazepine. The (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON stated monthly psychotropic summary report was not documented for Resident 67. On 09/18/25 at 9:08 A.M., during an interview, the DON stated the facility did not use psychotropic administration record. All the facility monitoring and the documentation including behavior, side effects & non-pharmacological interventions were documented on the MAR. On 9/18/25 at 11:24 A.M., during a concurrent interview and medical record review, the DON stated resident's psychotropic medications should be evaluated within 3 to 5 days of admission by psychiatry provider. A review of facility's policy titled Psychoactive/Psychotropic Medication Use revised April 2025, indicated .1. f. Residents who are admitted from the community or transferred from a hospital and who are already receiving psychotropic medications will be evaluated for the appropriateness and indications for use. Re-evaluation of the use of the psychotropic medication at the time of admission or soon thereafter, to consider whether the medication can be reduced or discontinued. 2. Psychotropic medication management. a. Management include . identifying person centered non-pharmacological interventions. e. Monitoring of a resident receiving psychotropic medication will include evaluation of the effectiveness of the medication, as well as assessment for possible adverse consequences. Behavioral symptoms are re-evaluated periodically. f. staff will monitor for potential adverse consequences. 3. d. vii. The facility must attempt, and document non-pharmacological approaches attempted in the medical record. A review of the Drug Information (https://dailymed.nlm.nih.gov/dailymed) for risperidone indicated tardive dyskinesia may develop in patients treated with antipsychotic drugs. Any patient treated with atypical antipsychotics should be monitored for symptoms of hyperglycemia (high blood glucose). Risperidone may induce orthostatic hypotension (sudden drop in blood pressure upon standing). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not provide proper vision treatment and assistive devices for one resident (Resident 18) in a timely manner.This failure had the potential for the resident to not receive timely vision treatment and glasses to maintain his highest practicable physical well-being and quality of life. Findings:Resident 18 was admitted to the facility on [DATE] per the facility's admission Record. On 9/15/25 at 11:11 A.M., An observation and interview was conducted with Resident 18 while inside his room. Resident 18 was sitting in a wheelchair at his bedside, fully dressed, reading a book. Resident 18 was squinting while reading. Resident 18 stated he wore glasses when he read but he did not have any here at the facility. Resident 18 stated he thought his glasses got lost in the ambulance on his way to the facility. Resident 18 stated he was an avid reader, and it was difficult to read his books without his glasses. Resident 18 stated he could not see the clock or tv. Resident 18 stated he could not see the activity calendar posted on the wall, so he did not participate in any activities because he did not know what was offered. Resident 18 stated, I've told them I need my glasses multiple times. Resident 18 stated he and was told the facility would try and get the Optometrist to see him. Resident 18 stated he did not know when he would see the Optometrist. A review of Resident 18's progress note dated 7/28/25 at 9:08 A.M., indicated, per SSD [Social Services Director], a referral for optometry was faxed to [fax number]. They will be in the facility in September.On 9/16/25 at 3:55 P.M., an interview was conducted with Certified Nursing Assistant 11 (CNA11). CNA11 stated she was aware that Resident 18 was unable to read without his glasses. CNA11 stated she looked for Resident 18's glasses in his bedside table and couldn't find them and had informed the licensed nurse that he had trouble reading his book and watching tv. On 9/17/25 at 9:24 A.M., an interview was conducted with CNA 12. CNA12 stated Resident 18 had told her he needed his glasses to read and watch tv and that they were missing. CNA12 stated she previously had notified the social worker and the nurse so they could provide Resident 18 with glasses. On 9/17/25 at 10:20 A.M., an interview was conducted with Licensed Nurse 13 (LN13). LN 13 stated that when Resident 18 made it known to the staff that he needed glasses, the social worker was notified, and an optometrist appointment was made for that resident. LN13 stated he was aware Resident 18 needed glasses and that he was on the list to see the Optometrist to get replacement glasses. LN 13 stated the Optometrist came to the facility once a month for custodial residents or more often if needed. LN13 stated he was unsure how follow up is done to notify the resident of an upcoming appointment with the Optometrist. On 9/17/25 at 10: 30 A.M., an interview was conducted with the SSD. The SSD stated the process for providing for a resident's glasses was for nursing to report the need to social services who would then follow up with the resident and make an appointment for the resident to see the Optometrist the next time he came to the facility. The SSD stated the Optometrist saw residents on a quarterly basis or if there was an emergency need, like an eye problem. The SSD stated Resident 18 was identified to need glasses in July, during daily rounds (a daily activity that helped identify resident's needs). The SSD stated Resident 18 missed the June Optometrist visit and that she had put Resident 18 on the list to see the Optometrist the next time he came to the facility, which was September. SSD stated that reading glasses had been offered to the resident but he refused them. On 9/18/2025 at 12:41 P.M. an interview and observation was conducted with Resident 18. Resident 18 was sitting at his bedside. Resident 18 was not wearing glasses. Resident 18 stated he still had not received glasses and was unsure when he would get any. Resident 18 stated he was offered reading glasses previously but he always refused because they don't work. Resident 18 stated he wore his glasses at home all the time because he could not see far. Resident 18 stated his life had been impacted because he could not see the clock or tv or participate in activities. On 9/18/25 at 2:47 PM, an interview was conducted with the Director of Nursing (DON). The DON stated her expectation was that when it was determined that the resident needed glasses (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Optometrist should have been notified. The DON stated the Optometrist should have been requested to come to facility as soon as possible. The DON stated Resident 18 should not have had to wait two months to see the Optometrist to get replacement glasses. A review of the facility's Optometric and Ophthalmology Consultation Agreement dated and signed 7/22/09 stated, .this provider to perform any and all eye care services .for selected residents . for whom services have been requested. A review of the facility's policy titled Social Services dated September 2021 indicated, .2. Medically-related social services are provided to maintain or improve each resident's ability to control everyday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.).e. making arrangements for obtaining needed items such as clothing and personal items.k. identifying and seeking ways to support resident needs through the assessment and care planning process.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure tap water temperatures were kept within a safe temperature range for one of six resident rooms (Resident 76's room). In addition, the facility failed to check the function of a wanderguard (a wearable wristband, that uses sensors and alarms to prevent residents at risk of wandering, like those with dementia, from leaving a designated safe area in a facility) for one sampled resident (67) per the manufacturer's guideline.This failure had the potential to have unsafe tap water temperature hot enough to scald Resident 7 and to put Resident 67's safety at risk. Findings: Resident 76 was admitted to the facility on [DATE] per the Resident admission Record. On 9/15/25 at 11:44 A.M., an observation and interview was conducted with Resident 76 in her room. Resident 76 stated the water from the bathroom sink faucet was very hot. Resident 76 stated she could not hold her hand under the running water. Resident 76 stated she had told the staff this many times but nothing had been done. An observation was done of the hot water in Resident 76's bathroom sink. The water was very hot to the touch. On 9/15/25 at 12:38 P.M., an interview was conducted with Certified Nursing Assistant (CNA) 14. CNA14 stated she was aware the water in the bathroom sink of Resident 76's bathroom was very hot. CNA14 stated the hot water had been reported to the maintenance director a while ago and that a bathroom maintenance request had been placed for Resident 76's bathroom sink. On 9/16/25 at 3:05 P.M., an observation was conducted in Resident 76's bathroom. The hot water in the bathroom sink was turned on and ran for four minutes. The water was hot to the touch. The water temperature was taken and the thermometer read 122.9 degrees Fahrenheit. On 9/16/25 at 3:32 P.M., an interview was conducted with the Maintenance Director (MTD). The MTD stated that he randomly checked hot water temperatures in a few resident rooms in each hallway every day. The MTD stated the hot water goal in each resident's room was 110-113 degrees Fahrenheit. The MTD stated the hot water temperature should never more than 120 degrees Fahrenheit. The MTD stated there was a log that had room water temperatures documented. On 9/16/25 at 3:32 P.M., an observation and interview was conducted with the MTD. The MTD went into Resident 76's bathroom and filled a plastic cup with hot water from the sink. The MTD was observed taking the temperature of the hot water in the cup with a thermometer. The MTD stated the temperature reading was 122-degree Fahrenheit. The MTD stated that the water temperature in the sink was too hot and should not be above 120 degrees Fahrenheit. On 9/18/25 at 2:47 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated that a hot water temperature of 122 degrees Fahrenheit was too hot and could cause a burn to a resident. The DON stated that her expectation was that the water temperature should have been tested as soon as the resident reported it was too hot and fixed immediately. A review of the facility's Water Temperature, Safety of policy dated January 2025 indicated Tap water in the facility shall be kept within a temperature range to prevent scalding of residents.1. Water (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	heaters that service resident rooms, bathrooms . shall be set to temperature range of 105-120 degrees Fahrenheit. A review of Resident 67's admission record dated 9/16/25, indicated resident was admitted on [DATE] for rehabilitation therapy, physical and occupational therapy with medical history including dementia (a brain disorder that causes a progressive decline in cognitive abilities such as memory, thinking, language, orientation, judgment, and problem-solving skills). A review of Resident 67's Elopement and Wandering Risk Observation/Assessment was done 7/24/25 and Resident 67 was assessed with a score of 24. Per the assessment, If the total score is 10 or greater, the resident would be considered At Risk for Wandering or Elopement. A review of Resident 67's physician's orders indicated a wanderguard and to check placement of wanderguard.every shift. was ordered on 7/24/25. On 09/17/2025 12:20 P.M., a concurrent interview and record review was conducted with licensed nurse (LN) 5. A record review of Resident 67's physician's orders indicated a wanderguard and to check placement of wanderguard.every shift. was ordered on 7/24/25. LN 5 stated the placement and function of a wanderguard should be checked every day by the nurse. LN 5 stated checking the function of a wanderguard daily should be ordered to ensure the device is working properly. A review of the facility policy titled Wandering and Elopements, dated March 2019, indicated if a resident is .identified as at risk for wandering.the resident's care plan will include strategies and interventions to maintain the resident's safety. A review of the undated WanderGuard system instruction manual indicated that the signaling device needs to be tested daily and to record the residents in the resident's record.

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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 interview and record review, the facility failed to manage the care related to intravenous (IV- delivery of fluids, medications, or nutrients into the body's bloodstream, usually through a needle or catheter inserted into a vein) therapy for three sampled residents (90, 124, 4) when:1. A peripherally inserted central catheter (PICC - a long, thin, flexible tube inserted into a vein in the arm and threaded into a large vein near the heart) line dressing was not assessed and changed per the facility's policy for Resident 90 and 124.2. The IV fluid intake was not documented per the facility's policy for Resident 4. This failure had the potential for medical complications related to the residents' IV therapy.1. Per the facility's admission Record, Resident 124 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (bone infection) of the vertebra (one of the individual bones that stack up to form the backbone).On 9/16/25 at 3:00 P.M., a concurrent interview and record review were conducted with Licensed Nurse (LN) 2. A review of Resident 124's physician's orders dated 8/15/25 indicated an order for IV - assess length of external catheter and upper arm circumference.During Dressing Changes. Every day shift every Sat. A review of Resident 124's IV Medication Administration Record (MAR - a report detailing the medications administered to a patient by a healthcare professional) indicated a dressing change of the PICC line was done on 8/23/25, 8/30/25, 9/6/25 and 9/13/25. Further review of each dressing change documentation indicated that a measurement of the arm circumference was not done as ordered by the physician. LN 2 stated the arm circumference should have been measured as ordered to ensure Resident 124's PICC line was working and intact. Per the facility's admission Record, Resident 90 was admitted on [DATE] with diagnoses that included osteomyelitis of the left ankle and foot. On 9/16/25 at 3:33 P.M., a concurrent interview and record review were conducted with LN 3. A review of Resident 124's physician's orders dated 9/6/25 indicated there was no order for the nurse to measure the PICC line's external catheter length and the resident's arm circumference during every dressing change. LN 3 stated there should have been an order so that nurses know if there is a problem with the PICC line's functioning. A review of the facility policy titled Central Venous Catheter Care and Dressing Changes, dated 6/2025, indicated that nurses are to .Measure the length of the external central vascular access device with each dressing change.measure arm circumference and compare to baseline.2. Per the facility's admission Record, Resident 4 was admitted to the facility on [DATE] with diagnoses that included congested heart failure (CHF -heart is unable to pump blood as effectively as it should) and Urinary Tract Infection (UTI - bladder infection).On 9/17/2025 at 10:32 A.M., a concurrent interview and record review were conducted with LN 5. Per Resident 4's physician's orders, on 9/10/25, Ertapenem (medication for infection) .use 1 gram intravenously every 24 hours for infection for 3 days. Further review of Resident 4's clinical record indicated that during the IV course, Resident 4's IV fluid intake amount was not recorded on 9/10/25 and 9/12/25. LN 5 stated that all residents who are on IV therapy need to have their IV fluid intake monitored and documented to detect possible fluid overload (when the body holds onto too much water, leading to swelling in places like the feet, ankles, or face, and can cause symptoms such as shortness of breath, a tight feeling in the stomach, or high blood pressure). A review of the facility policy titled Intake, Measuring and Recording, dated 7/2025, indicated that .Fluids taken intravenously are recorded by the licensed nurse.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the controlled drug records (CDR, records that are kept for drugs with high abuse potential) reconciled with the electronic medication administration record (EMAR) for four sampled residents (Resident 62, 92, 88, and 142). In addition, a controlled medication prescribed to Resident 62 could not be accounted for when it was wasted without a second nurse signature.This failure had the potential for the residents' (Resident 62, 92, 88, and 142) controlled drugs to be diverted (when a medication is taken for use by someone other than whom it is prescribed). Findings:1. A review of Resident 62's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of displaced comminuted fracture of shaft of right femur (break in the bone of the right leg). A review of Resident 62's physician orders indicated an order for oxycodone (a controlled pain medication) 5 milligram (mg) oral capsule on 8/6/25 for moderate to severe pain.A review of Resident 62's CDR indicated oxycodone 5 mg was removed on 8/10/25 at 3 A.M. In addition, Resident 62's oxycodone 5mg was documented as wasted on 9/2/25 at 7:46 A.M. and contained only one nurse signature.A review of Resident 62's EMAR indicated oxycodone 5 mg was not administered to the resident from 8/6/25 - 8/12/25 and 8/14/25 - 9/17/25.2. A review of Resident 92's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of surgical amputation (surgical removal of a limb) and migraine.A review of Resident 92's physician orders indicated an order for oxycodone 10 milligram oral tablet on 5/19/25 for severe pain.A review of Resident 92's CDR indicated oxycodone 10 mg was removed on 8/21/25 at 8:30 P.M., 8/22/25 at 7:45 P.M., 9/3/25 at 12 A.M., 9/5/25 at 4:55 P.M., and 9/8/25 at 9:10 P.M. A review of Resident 92's EMAR indicated oxycodone 10 mg was not given on 8/21/25 and 8/22/25. In addition, oxycodone 10mg was not administered to Resident 92 on 9/3/25 at 12 A.M., 9/5/25 at 4:55 P.M., and 9/8/25 at 9:10 P.M.3. A review of Resident 88's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of displaced trimalleolar fracture of right lower leg (break in the bones that form at the joint of the ankle).A review of Resident 88's physician orders indicated an order for oxycodone 5 mg oral tablet revised on 8/24/25 for moderate or severe pain.A review of Resident 88's CDR indicated oxycodone 5 mg was removed on 6/24/25 at 7:30 A.M., 7/24/25 at 12 A.M., 7/25/25 at 1 A.M., 8/17/25 at 1:44 A.M., 9/8/25 at 12:19 A.M. and 9:05 P.M. A review of Resident 88's EMAR indicated oxycodone 5mg was not administered to the resident on 6/24/25 at 7:30 A.M., 7/24/25 at 12 A.M., 7/25/25 at 1 A.M., 8/17/25 at 1:44 A.M., 9/8/25 at 12:19 A.M. and 9:05 P.M.4. A review of Resident 142's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of stable burst fracture of first lumbar vertebra (a condition where the vertebra of the lower back collapse).A review of Resident 142's physician orders indicated an order on 9/1/25 for hydrocodone-acetaminophen 5-325 mg (Norco, a controlled pain medication) oral tablet for severe pain.A review of Resident 142's CDR indicated Norco was removed on 9/13/25 at 12 P.M.A review of Resident 142's EMAR indicated Norco was not administered to the resident on 9/13/25 at 12 P.M.On 9/16/25 at 11:28 A.M., an interview and record review was conducted with Licensed Nurse (LN) 34. LN 34 reviewed Resident 142's CDR and EMAR for Norco and verified the discrepancy on 9/13/25. LN 34 stated Resident 142's Norco administration should have been documented on both the resident's CDR and EMAR.On 9/16/25 at 12 P.M., an interview and record review was conducted with LN 31. LN 31 reviewed the CDR and EMAR for Resident 62's oxycodone 5 mg and verified the discrepancy on 8/10/25. LN 31 verified her signature was present on Resident 62's oxycodone 5mg CDR for waste on 9/2/25 at 7:46 A.M. and stated, I told the day manager to sign too, and she must've forgot. LN 31 stated two nurses must sign on the CDR when a controlled drug needed to be wasted. LN 31 stated two nurse signatures on the CDR ensured the medication was wasted appropriately.LN 31 reviewed the CDR and EMAR for Resident 92's (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxycodone 10 mg and verified the discrepancies on 8/21/25, 8/22/25, 9/3/25, 9/5/25, and 9/8/25.LN 31 reviewed Resident 88's CDR and EMAR for oxycodone 5 mg and verified the discrepancies on 6/24/25, 7/24/25, 7/25/25, 8/17/25, and 9/8/25.On 9/18/25 at 10:42 A.M., an interview and concurrent record review was conducted with the Director of Nursing (DON). The DON stated prior to administering controlled drugs to the residents, the nurses must verify the order, sign off on the CDR using date and time, and sign off on the EMAR. The DON stated, if a controlled medication is signed out of the CDR it should also be present on the EMAR. The DON reviewed Resident 62's CDR and EMAR for oxycodone 5 mg and stated the CDR and EMAR did not reconcile on 8/10/25 at 3 A.M. The DON acknowledged there was only one signature for waste on 9/2/25 at 7:46 A.M. for Resident 62's oxycodone 10mg. The DON stated two nurses must sign to waste a controlled pain medication to ensure there was no diversion. The DON reviewed Resident 92's CDR and EMAR for oxycodone 10 mg and stated, These don't match. The DON verified the missing entries in the EMAR for Resident 2's oxycodone 10 mg on 8/21/25, 8/22/25, 9/3/25, 9/5/25, and 9/8/25.The DON reviewed Resident 88's CDR and EMAR for oxycodone 5 mg and verified they did not reconcile on 6/24/25, 7/24/25, 7/25/25, 8/17/25, and 9/8/25.The DON reviewed Resident 142's CDR and EMAR for Norco and verified they did not reconcile on 9/13/25.The DON stated her expectation was for the nurses to document appropriately, especially when administering controlled medications.A review of the facility's policy titled Controlled Substances, revised November 2022, indicated, .The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications.an individual resident controlled substance record is made for each resident who will be receiving a controlled substance.This record contains:.i. time of administration.l. signature of nurse administering medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the provider responded to the interim medication regimen review recommendations by the pharmacist for one (Resident 67) of 24 sampled residents. This failure resulted in unnecessary medications and inappropriately monitored medications for the Resident 67.A review of Resident 67's admission record initiated on 9/16/25, indicated resident was admitted on [DATE] for rehabilitation therapy, physical and occupational therapy with medical history including bipolar disorder (a chronic mental health condition characterized by extreme mood swings between mania (high energy and euphoria) and depression (low mood and lethargy), depression (a common and serious mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest in activities that were once pleasurable) & dementia (a general term for a group of brain disorders that cause a progressive decline in cognitive abilities, including: Memory, Thinking, Language, Orientation, Judgment, and Problem-solving skills). A review of Resident 67's order summary report showed mirtazapine 30 milligram (mg) tablet by mouth one time a day for depression, oxcarbazepine 300 mg tablet by mouth two times a day for bipolar disorder and risperidone 1 mg by mouth in the morning for bipolar disorder ordered on 7/23/25.Further review of Resident 67's medical record showed specific behaviors manifested were not identified and documented for oxcarbazepine and risperidone's use. Review of Resident 67's order summary report and the medication administration record did not show behavior and side effects monitoring for oxcarbazepine and risperidone. Further medical record review showed Resident 67 abnormal involuntary movement scale test (AIMS, a rating scale used to detect and monitor tardive dyskinesia [TD]. TD is a disorder involving involuntary, rhythmic, dance-like movements of the face, mouth, trunk, and limbs, which can be a side effect of long-term antipsychotic medication) was not performed. In addition, there was no initial admission assessment/evaluation of the psychotropic medications to determine whether to be reduced or discontinued. On 9/17/25 at 12:14 P.M., during an interview licensed nurse (LN) 41 stated Nurse Practitioner (NP) 42 was the psychiatry provider. On 9/17/25 at 12:39 P.M., an interview was conducted with NP 42 regarding Resident 67's psychotropic medications. NP 42 stated he had not been consulted for Resident 67. NP 42 stated the other psychiatry nurse practitioner may have been consulted. On 9/17/25 at 3:50 P.M., during an interview, the Director of Nursing (DON) stated the facility's consultant pharmacist was on vacation. During a concurrent interview and record review with the DON on 9/17/25 at 4:10 P.M., the DON verified Resident 67 has not been seen by any psychiatry provider and the resident's psychotropic medications have not been evaluated. On 9/18/25, a medical record review of Resident 67's interim medication regimen review dated 7/24/25, showed the following recommendations for psychotropic medications by the pharmacist:-Informed consent required-Add behavior and side effects monitoring-Antipsychotics: Perform abnormal involuntary movement scale test within 30 days of admission & every 6 months or TCAPO daily monitoring (systematically evaluating patients to ensure safe & effective use, focusing on adverse reactions, benefits & overall quality of life).-Routine Antipsychotic use must be evaluated by MD (the prescriber) on admission for potential dose reduction or discontinuation. On 9/18/25 at 11:24 A.M., during a concurrent interview and medical record review, the DON stated resident's psychotropic medications should be evaluated within 3 to 5 days of admission by psychiatry provider. The DON further stated providers should respond to the pharmacist's recommendation within 3 to 5 days. The DON acknowledged the provider did not respond to Resident 67's pharmacist recommendations of 7/24/25. A review of facility's policy titled Medication Regimen Reviews revised April 2007, indicated . 8. The Consultant Pharmacist will provide a written report to physicians for each resident with an identified irregularity. 9.The Consultant Pharmacist will provide the Director of Nursing Services and Medical Director with a written, signed (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and dated copy of the report, listing the irregularities found and recommendations for their solutions. 10. Copies of drug/medication regimen review reports, including physician responses, will be maintained as part of the permanent medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 15.5 percent. Five (5) medication errors were observed, a total of 33 opportunities, during the medication administration process for three (3) of eleven randomly observed residents (Resident 113, 10, and 140). As a result, the facility could not ensure medications were correctly administered to all residents.Findings:1. A review of Resident 113's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (a condition where blood flow to the brain is interrupted, causing brain tissue to die).On 9/15/25 at 9:05 A.M., an observation of Resident 113's medication administration was conducted with LN 36. LN 36 prepared Resident 113's medication at the medication cart. LN 36 placed aspirin 81 mg (milligrams) 1 oral tablet that was enteric coated into a clear medication cup. LN 36 verified the medication (aspirin 81 mg) that she would administer to Resident 113. LN 36 entered Resident 113's room and the resident swallowed the medication with water.A review of Resident 113's physician orders indicated, .Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day, Start date 8/27/25. Calcium Carbonate Tablet Chewable 500 MG Give 1 tablet by mouth one time a day, Start date 8/27/25.On 9/15/25 at 11:53 A.M., an interview and record review was conducted with LN 36. LN 36 stated she administered enteric coated aspirin 81mg to Resident 113. LN 36 reviewed Resident 113's electronic medication administration record (eMAR) and stated she should have administered the chewable form of aspirin 81. LN 36 stated the form of the medication (aspirin 81 mg) she administered to Resident 113 was considered an error. LN 36 stated she should have administered Carbonate Tablet Chewable 500mg to Resident 113 since it was due at that time. LN 36 stated she should have verified the correct medications on Resident 113's eMAR.2. A review of Resident 10's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of type 2 diabetes mellitus.On 9/15/25 at 9:43 A.M., an observation of Resident 10's medication administration was conducted with LN 37. LN 37 prepared Resident 10's medication at the medication cart. LN 37 put Resident 10's pioglitazone 30 mg (a medication given for diabetes) oral tablet in a clear plastic cup with the other medications. LN 37 verified the medications to be administered to Resident 10 were due at that current time. LN 37 entered Resident 10's room and the resident swallowed the verified medications with water.A review of Resident 10's physician orders indicated, .Actos Tablet 30 MG (Pioglitazone HCl [hydrochloride) Give 1 tablet by mouth one time a day for Diabetes, start date 8/27/25.A review of Resident 10's eMAR, indicated Actos Tablet 30 mg (Pioglitazone HCl) was scheduled for administration at 7:30 A.M.On 9/15/25 at 12:30 P.M., an interview was conducted with LN 37. LN 37 verified that he had administered pioglitazone 30 mg to Resident 10 around 9:43 A.M that morning. LN 37 stated the due time for Resident 10's pioglitazone 30 mg was 7:30 A.M. and the medication should not have been given past 8:30 A.M. LN 37 stated he must've missed that and pioglitazone 30 mg given to Resident 10 over an hour past due time was considered a medication error.3. A review of Resident 140's admission Record indicated the resident was admitted to the facility on [DATE] with a diagnosis of unspecified blepharitis left lower eyelid (inflammation of the eyelid generally caused by bacterial overgrowth).On 9/16/25 at 8:30 A.M., an observation of Resident 140's medication administration was conducted with LN 39. LN 39 prepared Resident 140's medication at the medication cart. LN 39 prepared Resident 10's aspirin 81 mg chewable oral tablet and put the medication in a clear plastic cup. LN 39 then measured Resident 10's polyethylene glycol 3350 17000 mg powder for oral solution (MiraLAX, a medication that helps to prevent and treat constipation) poured the powder into a clear cup, poured in approximately six (6) ounces of water, and stirred the mixture with a plastic disposable spoon. LN 39 verified the medications (aspirin 81 mg chewable, MiraLAX) that she would administer to Resident 10. LN 39 entered Resident 10's room and (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered six ounces MiraLAX. LN 39 then administered Resident 10's aspirin 81 mg chewable oral tablet and the resident swallowed it with water.A review of Resident 140's physician orders indicated, .Aspirin Oral Tablet Chewable 81 MG (Aspirin) Give 1 tablet by mouth one time a day, Start date 8/27/25.Polyethylene Glycol 3350 Oral Packet 17 GM (Polyethylene Glycol 3350) Give 1 packet by mouth one time a day for (constipation prevention) *Mix thoroughly with 8 oz of water, Start date 8/27/25.On 9/16/25 at 2:49 P.M., an interview was conducted with LN 39. LN 39 verified that she had administered chewable aspirin 81 mg tablet and MiraLAX with 6 ounces of water to Resident 10. LN 39 stated Resident 10 swallowed the chewable aspirin 81 mg tablet, and she should have instructed the resident to chew the tablet. LN further stated she should have mixed the MiraLAX with eight (8) ounces of water instead of 6 ounces. On 9/18/25 at 10:42 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated all resident's (Resident 113, 10, and 140) medications should have been administered according to the physician orders. The DON stated her expectation was for the nurses to verify all resident's medications with the eMAR and notify her and the Medical Doctor if there were any discrepancies.A review of the facility's policy titled Administering Medications, revised April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed.Medications are administered with prescriber orders, including any required time frame.Medications are administered within one (1) hour of their prescribed time.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were stored according to acceptable standards of practice in four of eleven sampled medication carts when:1. A crash cart (a cart filled with supplies and medication used during a health emergency) did not contain sterile water, ky jelly, and alcohol swabs.2. A treatment cart contained an expired bottle of Derma Pak -its iodoform packing strip (medicated pieces of cloth used to pack inside of wounds to promote healing) and Clotrimazole cream (a medicated cream used to treat fungal infections of the skin) for Resident 57 without an active order.3. A medication cart contained Assure Dose glucometer drops with an open date of [DATE].This failure had the potential for medication to have reduced effectiveness and/or medication misuse. Findings:1. A review of the facility's document, undated, titled Crash Cart Checklist, indicated items that should have been included in the facility's crash cart, .Alcohol wipes, Sterile Water, K-Y Jelly.On [DATE] at 9:09 A.M., an observation and interview was conducted with Licensed Nurse (LN) 32 of the facility's crash cart. LN 32 opened the crash cart for observation of the items. The crash cart was observed to be missing alcohol wipes, sterile water, and KY jelly. LN 32 confirmed the missing items and stated the crash cart should have contained all required items according to the crash cart checklist. 2. On [DATE] at 9:32 A.M., an observation and interview was conducted with LN 33 of the facility's treatment cart. A bottle of Derma Pak -its iodoform packing strip was observed in the top drawer with a expiration date of 2023-03-23. A box of Clotrimazole cream for Resident 57 was observed in the second drawer of the treatment cart with a label apply cream topically every evening to tinea pedis [fungal infection of the skin on the feet] until [DATE]. LN 33 confirmed the bottle of Derma Pak -its iodoform packing strip was expired and stated it should have been thrown away. LN 33 observed Resident 57's Clotrimazole cream and stated Resident 57 did not have an active order for it and the cream should have been taken out of the cart.A review of Resident 57's admission record indicated the resident was admitted to the facility on [DATE] with a diagnosis of displaced fracture of base of neck of right femur (a break in the right leg bone). A review of Resident 57's physician orders indicated an order for Clotrimazole Cream starting on [DATE] and ending on [DATE].A review of Resident 57's electronic medication administration record (EMAR) indicated the resident last received the Clotrimazole Cream on [DATE].3. On [DATE] 11:28 A.M., an observation and interview was conducted with LN 34 of the facility's medication cart. A box of Assure Dose glucometer drops was observed in the top drawer of the cart with an open date of [DATE]. The box of Assure Dose drops indicated .Use within 90 days after first opening. LN 34 verified the drops were expired and stated they can only be used for 90 days, and the drops should have been thrown away.On [DATE] at 10:42 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated the facility's crash cart should have contained all the required items according to the checklist and could have affected the emergent care if items were missing. The DON stated the treatment cart should not have contained the expired Derma Pak -its iodoform packing strip and it could have affected the resident's health if they were used. The DON further stated the treatment cart should not have contained Resident 57's cream without an active physician order. The DON stated the medication cart should not have contained the expired Assure Dose drops and the drops could have affected the glucometer (machine used to test blood sugar levels) accuracy. A review of the facility's policy titled Emergency Cart Supplies and Equipment, undated, indicated, .It is the responsibility of the Director of Nurses or his/her designee to assure.is routinely checked for completeness.The facility's policy titled Medication Labeling and Storage, revised February 2023, did not provide guidance on monitoring for expired items or medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviara Healthcare Center	944 Regal Road Encinitas, CA 92024

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pneumococcal vaccine was offered to one of five residents (Resident 124).This failure had the potential to put Resident 124 at greater risk in developing pneumococcal due to their comorbidities.Findings:A review of Resident 124's admission Record, Resident 124 was admitted on [DATE] with a diagnosis of Orthopedic aftercare following surgical amputation (cutting off a limb), other comorbidities include diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).On 9/18/25 at 10:24 A.M., an interview and record review was conducted with the Infection Preventionist Nurse (IP). The IP stated when a new resident was admitted a review of vaccinations through the CAIRS (California vaccine registry) was done to see if the resident needed Pneumococcal vaccination. The IP stated if the resident needed a Pneumococcal vaccination, the physician would be contacted to get orders. The IP reviewed Resident 124's vaccination record and stated there was no documentation that the resident was offered or refused Pneumococcal vaccine. The IP reviewed Resident 124's Vaccine Informed Consent ([NAME]) form. The IP stated the form was blank and indicated there was no recorded vaccinations. The [NAME] was signed by Resident 124 and not dated and was signed by staff member dated 9/6/25. The IP stated there should have been documentation to show Resident 124 was offered or refused the Pneumococcal vaccine. The IP stated she followed the CDC (Center for Disease Control and Prevention) guidelines, and Resident 124 should have been offered the Pneumococcal vaccine.The IP reviewed the CDC's Pneumococcal Vaccine Timing for Adults dated March 2025, Adults aged 19 through 64 with chronic health conditions including diabetes mellitus. The IP stated she should have contacted the physician to discuss which Pneumococcal vaccine should have been offered to Resident 124.On 9/18/25 at 2:39 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated residents were given immunization information regarding Pneumococcal vaccine upon admission. The DON stated Resident 124 should have been offered the Pneumococcal vaccine. The DON stated her expectation was for all newly admitted residents to be offered the Pneumococcal vaccine and for the LN to document if the resident received or refused the vaccination.A review of the facility's undated CDC vaccine information sheet titled Pneumococcal Conjugate Vaccine indicated .2. Adults 19 through [AGE] years old with certain medical or other risk factors who have not already received pneumococcal conjugate vaccine should receive pneumococcal conjugate vaccine.A review of facility policy title Vaccination of Residents, dated October 2019, indicated, All residents will be offered vaccines that aid in prevention infectious diseases. 3. All new residents shall be assessed for current vaccination status upon admission.5. If vaccines are refused, the refusal shall be documented in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555323	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Covid-19 immunization was offered to one of five residents (Resident 124).This failure had the potential to put Resident 124 at greater risk in developing Covid-19 due to their comorbidities.Findings:A review of Resident 124's admission Record, Resident 124 was admitted on [DATE] with a diagnosis of Orthopedic aftercare following surgical amputation (cutting off a limb), other comorbidities include diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing).On 9/18/25 at 10:24 A.M., an interview and record review was conducted with the Infection Preventionist Nurse (IP). The IP stated when a new resident was admitted a review of vaccinations through the CAIRS (California vaccine registry) was done to see if the resident needed Covid-19 vaccination. The IP stated if the resident needed a Covid-19 vaccination, the physician would be contacted to get orders. The IP reviewed Resident 124's vaccination record and stated there was no documentation that the resident was offered or refused Covid-19 vaccine. The IP reviewed Resident 124's Vaccine Informed Consent ([NAME]) form. The IP stated the form was blank and indicated there was no recorded vaccinations. The [NAME] was signed by Resident 124 and not dated and was signed by staff member dated 9/6/25. The IP stated there should have been documentation to show Resident 124 was offered or refused the Covid-19 vaccine. The IP stated she followed the CDC (Center for Disease Control and Prevention) guidelines, and Resident 124 should have been offered the Covid-19 vaccine. On 9/18/25 at 2:39 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated residents were given immunization information regarding Covid-19 vaccine upon admission. The DON stated Resident 124 should have been offered the Covid-19 vaccine. The DON stated her expectation was for all newly admitted residents to be offered the Covid-19 vaccine and for the LN to document if the resident received or refused the vaccination.A review of the facility's undated CDC vaccine information sheet titled Covid-19 Vaccine indicated, . 1. Older adults and people of any age with certain underlying medical conditions (like heart or lung disease or diabetes) are more likely to get very sick with Covid-19.A review of facility policy title Vaccination of Residents, revised October 2019, indicated All residents will be offered vaccines that aid in prevention infectious diseases . 3. All new residents shall be assessed for current vaccination status upon admission. 5. If vaccines are refused, the refusal shall be documented in the resident's medical record.