

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555567	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/12/2026
NAME OF PROVIDER OR SUPPLIER South Coast Global Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 South Bristol Street Santa Ana, CA 92704	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure four of four residents (Residents 8, 12, 14, and 25) reviewed for accidents remained free from accident hazards. * The facility failed to ensure both side rails were padded for Resident 8, as per the physician's order and as care planned for Resident 8, due to the risk of injury from their seizure disorder. * The facility failed to ensure Resident 12's bilateral side rails were used as per the physician's order and failed to ensure Resident 12's bed was in the lowest position to prevent/minimize any injuries in the event Resident 12 had a seizure episode. Additionally, the facility failed to ensure two staff members assisted in the transfer of Resident 12 from the shower gurney back to the bed as per the facility's P&P. * Resident 14 had a diagnosis of seizure disorder with a history of seizures at the facility. Resident 14 had a physician's order for padded side rails. The facility failed to implement the physician's order which placed the resident at risk for injuries. * Resident 25 was totally dependent on the staff for transfer to and from his bed to a chair. A CNA independently transferred Resident 25 from a Geri-chair to his bed using a Hoyer lift. These failures had the potential to place the residents at risk for serious injuries. Findings: Review of the facility's P&P titled Transfer Policy dated 9/2025 showed the purpose of the transfer policy is to ensure the resident environment remains as free from accident hazards as possible, and each resident receives adequate supervision and provides supervision and assistive devices to prevent avoidable accidents. Procedure for the mechanical lift requires two-person assistance for transferring when using the mechanical lift with residents that are non-ventilator dependent. 1. Medical record review for Resident 25 was initiated on 1/5/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Care Plan titled At Risk for Falls due to quadriplegia dated 11/2025 showed to transfer Resident 25 via Hoyer lift with two-person assistance. Review of Resident 25's MDS dated [DATE], showed Resident 25 was totally dependent on the staff for transfer to and from his bed to a chair, with two or more staff required for Resident 25 to complete the activity. Review of Resident 25's Physician Order Report showed a physician's order dated 12/23/25, for the use of a Hoyer lift, with two-person assistance when Resident 25 needed to be transferred. On 1/7/26 at 1609 hours, an observation and concurrent interview for Resident 25 was conducted with CNA 5. CNA 5 was observed independently transferring Resident 25 from a Geri-chair to his bed, using a Hoyer lift. Resident 25 was observed suspended in the air lying on the Hoyer lift sling, in (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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory services for four of four sampled residents (Residents 7, 10, 12, and 25) reviewed for respiratory care. * The facility failed to ensure Resident 7's ventilator circuit set-up and in-line suction catheter changes were done as per the physician's orders. * The facility failed to ensure Resident 10's ventilator high-pressure alarm was set within a safe parameter. * The facility failed to ensure Resident 12 's oxygen flowmeter was set to the appropriate liter flow to match the aerosol mist setting as per the physician's order. In addition, the facility failed to ensure the flowmeter was in working condition. * The facility failed to provide Resident 25 continuous oxygen therapy during the transfer from a Geri-chair to his bed using a Hoyer lift. These failures had the potential to result in negative health outcomes for the residents. Findings: Review of the facility's P&P titled Oxygen Therapy dated 4/2024 showed it is the policy of the facility that oxygen therapy is administered as ordered by the physician. 1. Medical record review for Resident 25 was initiated on 1/5/26. Resident 25 was admitted to the facility on [DATE]. Review of Resident 25's Physician Order Report showed a physician's order dated 11/11/25, for aerosol mist to tracheostomy via T-piece or trach mask at 60% FI02. Review of Resident 25's care plan titled Tracheostomy revised on 11/2025 showed a care plan problem to address Resident 25's altered respiratory status due to tracheostomy secondary to a diagnosis of chronic respiratory failure and traumatic brain injury. The care plan goals included maintaining adequate ventilation as evidenced by patent airway and normal oxygen saturations. The care plan approaches included aerosol mist to trach via T-piece or trach mask with FI02 of 60%, and titration of FI02 to maintain oxygen saturation greater than 92%. On 1/7/26 at 1609 hours, an observation and concurrent interview was conducted with CNA 5. CNA 5 was observed independently transferring Resident 25 from a Geri-chair to his bed using a Hoyer lift. Resident 25 was observed suspended in the air lying on the Hoyer lift sling in between the Geri-chair and his bed. Resident 25 was observed with a tracheostomy; however, Resident 25 was not receiving supplemental oxygen. CNA 5 was asked if she was aware of Resident 25's medical condition and specifically if Resident 25 required continuous oxygen therapy. CNA 5 stated she did not know anything about the oxygen or the equipment and did not know whether Resident 25 required continuous oxygen therapy. CNA 5 stated she worked for the registry and she was not familiar with Resident 25. A bedside oxygen flow meter and venturi device were observed attached to the wall adjacent to Resident 25's bed. The venturi device was set at a rate of 60% FI02. A bottle of sterile water was attached to the venturi device and corrugated breathing tubing was observed attached to the sterile water bottle. However, the distal end of the corrugated breathing tubing was not attached to Resident 25's tracheostomy piece. CNA 5 was asked if she had observed Resident 25's corrugated breathing tubing disconnect from Resident 25's tracheostomy piece. CNA 5 stated she noticed Resident 25's oxygen tubing (corrugated breathing tubing) was disconnected from Resident 25 when she transferred Resident 25 from his Geri-chair onto the Hoyer lift, which occurred approximately two minutes ago. CNA 5 was asked if the corrugated breathing tubing should be connected to Resident 25's tracheostomy piece, to which CNA 5 replied, I don't know. CNA 5 was then asked if she should have notified the licensed nurse when Resident 25's corrugated breathing tubing was disconnected (continued on next page)		

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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. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program from August 2025 through December 2025. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. The facility failed to ensure the Surveillance Data Collection Form was complete and accurate to determine whether the resident's infection met the McGeer's criteria for true infection. * The facility failed to ensure the residents' clean linen cart was covered and failed to ensure the clean linen cart did not contain the residents' towels lying on top of the cart. These failures have the potential risk for not identifying, managing, containing, and controlling the transmission of communicable disease within the facility. Findings: 1. Review of the facility's P&P titled Infection Control and Surveillance revised 9/2025 showed it is the policy of the facility to closely monitor all residents who exhibit signs and symptoms of infection. The infection control program will: - develop prevention, surveillance, and control measures to protect residents and personnel from hospital-acquired infections. - perform surveillance activities to monitor and investigate causes of infections and manner of spread in order to prevent infections in the facility. - analyze clusters of infections, changes in prevalent organisms, and any increase in the rate of infection in a timely manner. When a resident exhibits signs and symptoms of suspected infection, the charge nurse will record the resident's name on the initial Infection Surveillance Form, follow routine procedures for notifying the attending physician and family. The ICP (Infection Control Preventionist) will gather further data for infection tracking and reporting and provide consultation and education as needed. Complete Infection Control Reports will be presented at quarterly Quality Improvement and Medical Staff meeting and will be available to all staff for review upon request. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from July 2025 through December 2025, showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's Criteria (DNMC): - July 2025: a total of 23 infections, including 13 HAIs, three CAIs, and six DNMCs. - August 2025: a total of 17 infections, including nine HAIs, and eight DNMCs. - September 2025: a total of nine infections, including four HAIs, and three DNMCs. - October 2025: a total of 18 infections, including 10 HAIs, two CAIs, and six DNMCs. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- November 2025: a total of 18 infections, including eight HAIs, one CAI, and nine DNMCs. - December 2025: a total of 22 infections, including 14 HAIs, one CAI, and five DNMCs. Further review of the facility's monthly Infection Control Surveillance Logs from July 2025 through December 2025 showed all the residents determined to have either an HAI, CAI, or DNMC were also prescribed the antimicrobial medications. There was no documented evidence the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications were included in the monthly surveillance logs. On 1/12/26 at 1102 hours, an interview and concurrent facility document review was conducted with the IP. The IP stated he was responsible for the infection control and surveillance of infections in the Sub-Acute unit. The IP stated the purpose of infection surveillance in the facility was to utilize the data collected to track and trend the resident infections, to guide interventions, and to prevent the transmission of organisms and the spread of infections in the facility. The IP stated when the resident exhibited signs and/or symptoms of an infection, or any change of condition, the charge nurse would conduct an assessment and inform the physician. The IP stated following the results of any ordered laboratory or diagnostics tests, the licensed nurse would inform the physician and the antimicrobial therapy would be prescribed. The IP stated once the antimicrobial therapy was prescribed, the IP would complete the McGeer's criteria form to determine if the resident had a true infection. The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed the antimicrobial medication, if the facility initiated the McGeer's criteria form for those residents and included those residents in the facility's infection surveillance program (from July 2025 to December 2025). The IP stated the McGeer's criteria form was only initiated for the residents with signs and/or symptoms of infection and were prescribed the antimicrobial medications. The IP stated the residents who were prescribed the antimicrobial therapy would be included in the infection surveillance and be included on the monthly Infection Surveillance Log. The IP was asked how many residents in the facility had infections (met McGeer's criteria) and were not prescribed the antimicrobial medications (from July 2025 through December 2025). The IP stated he did not know as the facility did not complete the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infections and were not prescribed the antimicrobial medications. Review of the McGeer's criteria form for Residents 11, 19, 22, 26, and 31 was conducted with the IP. The residents' McGeer's criteria form showed the following documentation: * For Resident 26, the report showed the following: - the antibiotic treatment prescribed for Resident 26 was Merrem 1 gm three times a day and Zyvox 600 mg two times a day for blood stream infection, to start on 8/27/25. - Yes was selected in the section on the form to indicate whether the infection met the NHSN criteria for a true infection. - further review of the form showed blood cultures 1 and 2 were collected and showed no growth. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* For Resident 31, the report showed the following: - the antibiotic treatment prescribed for Resident 34 was cefepime 1 gm two times a day and vancomycin 750 mg for one dose and 1 gm three times a day for pneumonia, to start on 8/27/25. - No was selected in the section on the form to indicate whether the infection met McGeer's criteria for a true infection. - further review of the form showed the documentation on 8/27/25, the chest x-ray showed small left pleural effusion, increased sputum production and temperature 100.8 degrees F. (all three criteria for pneumonia were met, however, the infection was marked as DNMC). * For Resident 19, the report showed the following: - the antibiotic treatment prescribed for Resident 19 was Merrem 1 gm three times a day for pneumonia, from 9/23/25 to 10/3/25. - Yes was selected in the section on the form indicate whether the infection met McGeer's criteria for a true infection. - further review of the form showed the documentation on 9/21/25, the chest x-ray showed unremarkable chest. * For Resident 22, the report showed the following: - the antibiotic treatment prescribed for Resident 22 was Zosyn 3.375 gm four times a day for seven days from 9/26 to 10/3/2025. - NO was selected in the section on the form to indicate whether the infection met the NHSN criteria for a true infection. However, review of the Surveillance Log for September 2025 failed to show the selection of DNMC for the infection on the log. * For Resident 11, the report showed the following: - indications: elevated WBC, low BP, increase sputum production - the antibiotic treatment prescribed for Resident 11 was Fortaz 1 gm three times a day for seven days from 12/18 to 12/25/25, for bronchitis. - YES was selected in the section on the form to indicate whether the infection met the McGeer's criteria for a true infection. - Under the section for McGeer's criteria for bronchitis showed for the lower respiratory tract, all three criteria must be present. For criteria 2- at least two respiratory sub criteria must be present; however, only one was documented (increased sputum). The IP reviewed the medical records and McGeer's criteria form for Residents 11, 19, 22, 26, and 31 and verified the McGeer's criteria forms were inaccurate. The IP stated the McGeer's criteria form and the determination of a true infection should be accurate to effectively conduct surveillance and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	track the prevalence of infections in the facility. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Linen Handling revised 12/2009 showed proper linen handling techniques will be used to protect against the transmission of organisms from one location to another. On 1/5/26 at 1002 hours, an observation and concurrent interview was conducted with LVN 6. The clean linen cart was observed with residents' gowns and bed linens inside of the cart. The clean linen cart cover was hanging on the side of the cart and not covering the clean linen. On top of the clean linen cart a plastic bin was observed with a razor and towels inside. Underneath the plastic bin were two towels. LVN 6 verified the findings. LVN 6 stated neither clean towels nor used towels should be stored on top of the cart for infection control. Additionally, LVN 6 stated the clean linen cart cover should be in place to cover the clean linens stored inside of the cart, to ensure the linens remain clean for infection control.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure care was provided in a manner which promoted dignity and respect for two of 14 final sampled residents (Residents 5 and 6). * The facility failed to ensure Resident 5 and 6's urinary output drainage bags were stored inside of the privacy bag. This failure had the potential to compromise Resident 5 and 6's rights to be treated with respect and dignity. Findings: Review of the facility's P&P titled Dignity Bags Utilization reviewed 9/2025 showed each resident who utilized a urinary catheter with an attached drainage bag would be provided with a dignity bag. 1. Medical record review for Resident 5 was initiated on 1/5/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 10/13/25, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's Physician Order Report for January 2026 showed a physician's order dated 7/15/25, for suprapubic catheter sized 8.5 French to gravity drainage due to urinary stricture. On 1/5/26 at 1010 and 1543 hours, Resident 5 was observed lying in bed and the urinary drainage bag was hanging on Resident 5's left side rail. The urinary drainage bag had yellow colored output. The urinary drainage bag was not inside a privacy bag. On 1/5/26 at 1548 hours, an observation of Resident 5 and concurrent interview was conducted with LVN 2. LVN 2 stated Resident 5 had a suprapubic catheter and the urinary drainage bag should have been stored inside of a privacy bag to provide the resident with privacy and dignity. LVN 2 verified the above findings. On 1/12/26 at 1451 hours, an interview was conducted with the DON. The DON stated for the residents with the urinary drainage bags, the urinary drainage bags should be placed inside of the privacy bag to provide the residents with dignity. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings. 2. Medical record review for Resident 6 was initiated on 1/5/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's Physician Order Report showed an order dated 4/15/22, for a suprapubic catheter to gravity drainage for urinary retention. On 1/5/26 at 1543 hours, an observation of Resident 6 and concurrent interview was conducted with LVN 6. Resident 6 was lying in his bed. Resident 6's urinary drainage bag was hanging from Resident 6's bed. Resident 6's urinary drainage bag was full of urine and without a privacy cover in place. LVN 6 verified the findings and stated Resident 6's urinary drainage bag should have been covered with a privacy cover to ensure Resident 6's dignity.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to maintain a homelike environment for four of 14 final sampled residents (Residents 5, 12, 14, and 25). * Resident 5 resided in Room C. The emergency outlet on the wall behind Resident 5's head of bed was observed in disrepair with chipped paint, wall debris and an opening above the red wall plate and the wall. * Resident 12 resided in Room A. The wall at the foot of Resident 12's bed was observed in disrepair with chipped paint and unpainted areas. * Residents 14 and 25 resided in Room B. The walls behind the residents' beds were observed in disrepair, as evidenced by scratches, chipped drywall, and peeled paint. These failures had the potential to negatively impact the residents' quality of life. Findings: 1. On 1/5/26 at 1006 hours, Resident 5 was observed lying in his bed in Room C. The emergency outlet on the wall behind Resident 5's head of the bed was exposed with an opening (or not sealed), chipped paint and wall debris above the wall plate. 2. On 1/6/26 at 0856 hours, Resident 12 was observed lying in bed in Room A. The wall at the foot of Resident 12's bed had chipped paint and unpainted areas. On 1/6/26 at 1605 hours, an observation of Rooms A and C and concurrent interview was conducted with the DON. The DON verified the above findings and stated the resident rooms needed to be in good repair and the facility should ensure a homelike and presentable environment for the residents. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings. 3. On 1/6/26 at 1600 hours, an observation and concurrent interview was conducted with the DON. Residents 14 and 25 resided in Room B. The walls behind the residents' beds were observed in disrepair, as evidenced by scratches, chipped drywall, and peeled paint. The DON verified the findings and stated the residents' room should be presentable and homelike. The DON stated the walls needed to be repaired.		

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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, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 18) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure Resident 18's orthostatic BP was monitored for the use of the Seroquel (antipsychotic medication). * The facility failed to ensure Resident 18's nonpharmacological interventions and its effectiveness were documented for the documented observed behaviors related to the use of the Zoloft (antidepressant medication). These failures had the potential for Resident 18 to experience potential harm from the adverse consequences from the use of the Seroquel medication and prevented the facility from accurately monitoring the effectiveness of the behavioral interventions in an effort to discontinue the use of the Zoloft medication. Findings: Review of the facility's P&P titled Medication, Psychotropic/Chemical Restraint reviewed 9/2025 showed Nursing and Social Services document in their progress notes the interventions and resident's response to treatment. Record and incorporate into the plan of care any non-drug interventions for the specific mood or behavior problem. Use the Psychotherapeutic Drug Summary Sheet to document the ongoing summary of behavior data, PRN doses, adverse reactions, and observations along with dosage changes and the rationale for changes. Medical record review for Resident 18 was initiated on 1/5/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's MDS assessment dated [DATE], showed Resident 18 had severe cognitive impairment and had diagnoses including psychotic disorder and depression. a. Review of Resident 18's Clinical Summary Report dated 11/25/25, showed a physician's order to administer Seroquel 150 mg via GT every 12 hours for psychosis manifested by striking out to staff. Review of Resident 18's care plan for the Seroquel medication dated 6/5/25, showed the interventions included observing the resident closely for significant side effects and report to the physician. Postural hypotension was listed under side effects. Review of Resident 5's Routine Psychotropic Medication forms for the Seroquel medication for 12/2025 and 1/2026 showed the licensed nurse's documentation on monitoring Resident 18 for adverse side effects related to using the Seroquel medication. The forms showed from 12/1 to 12/31/25 and from 1/1 to 1/6/26, the licensed nurses documented zero 0 adverse reactions were observed, every shift. Review of Resident 18's medical record failed to show the documentation of the monitoring for the orthostatic hypotension for Resident 18's use of the Seroquel medication. On 1/7/26 at 1336 hours, an interview and concurrent medical record review for Resident 18 was conducted with LVN 7. LVN 7 stated Resident 18 was taking the Seroquel medication for the behavior of striking out to the staff. LVN 7 stated every shift the licensed nurse monitored Resident 18 for the potential side effects related to the use of the Seroquel medication. LVN 7 stated postural hypotension was a potential side effect related to the Seroquel medication. When asked how postural hypotension was monitored, LVN7 stated the blood pressure reading should be obtained in different positions and compared, to determine if there was drop in the blood pressure related to the position change. When asked, LVN 7 stated Resident 18 was able to get into the sitting position from the lying position and should be monitored for orthostatic hypotension. When asked how postural hypotension was being monitored for Resident 18, LVN 7 stated Resident 18's vital signs, including his blood pressure reading, were obtained every shift, however, Resident 18's blood pressure reading was not monitored in the different positions and the blood pressure readings were not compared to monitor for orthostatic hypotension. LVN 7 reviewed Resident 18's medical record and stated she was unable to find the blood pressure monitoring for orthostatic hypotension for the use of the Seroquel medication. b. Review of Resident 18's Clinical Summary Report dated 11/25/25, showed a physician's orders to administer Zoloft (antidepressant) 50 mg via GT daily for depression manifested by self-isolation. Review of Resident 18's Routine Psychotropic Medication form for Zoloft 50 mg for 11/2025 showed (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 11/17/25, the licensed nurse documented two observed behaviors during the 0700 to 1900 shift. Further review of the Routine Psychotropic Medication Record failed to show the documentation for the nonpharmacological interventions implemented and its effectiveness for the above observed behaviors. Review of Resident 18's Routine Psychotropic Medication form for Zoloft 50 mg for 12/2025 showed the licensed nurse documented on 12/2/25, one observed behavior during the 0700 to 1900 shift. Further review of the Routine Psychotropic Medication Record failed to show the documentation for the nonpharmacological intervention implemented and its effectiveness for the above observed behavior. On 1/7/26 at 1336 hours, an interview was conducted with LVN 7. LVN 7 stated Resident 18 was administered the Zoloft 50 mg medication daily for depression. LVN 7 stated for the use of the Zoloft medication, Resident 18 was monitored every shift for the observed behaviors of self-isolation. LVN 7 stated if the manifested behavior was observed, the nonpharmacological interventions should be implemented and its effectiveness documented on the back of the Routine Psychotropic Medication form for Zoloft. On 1/7/26 at 1434 hours, an interview and concurrent medical record review for Resident 18 was conducted with the DON. The DON stated for the residents who were administered the psychotropic medications, the manifested behavior related to the use of the medication was monitored every shift by the licensed nurse. The DON stated if the behavior was observed, the licensed nurse should assess the resident for pain, incontinence, need for position changes, and implement the nonpharmacological interventions and document its effectiveness on the Routine Psychotropic Medication flowsheet. The DON reviewed Resident 18's Routine Psychotropic Medication flowsheet for Zoloft for 11/2025 and 12/2025 and verified the above findings. The DON stated the nonpharmacological interventions should be implemented and documented for each observed behavior and its effectiveness documented. The DON stated the licensed nurses were also responsible for monitoring the residents prescribed the antipsychotic medications for side effects and adverse reactions. The DON stated the potential side effects of antipsychotic medications included tardive dyskinesia, increased heart rate, or orthostatic hypotension. When asked how orthostatic hypotension should be monitored, the DON stated the resident's BP reading should be obtained in two different positions and compared. The DON further stated for the residents who were able to tolerate the lying and sitting position, the BP readings for each position should be obtained and compared. When asked how orthostatic hypotension was being monitored for Resident 18, the DON stated the facility was not checking for orthostatic hypotension for the resident. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was implemented for three of 14 final sampled residents (Residents 14, 22 and 8). * The facility failed to ensure Resident 8's side rails were padded in accordance with the resident's plan of care. * The facility failed to ensure Resident 14's side rails were padded and the bilateral heel protectors were applied in accordance with the resident's plan of care. * The facility failed to ensure Resident 22's bilateral heel protectors were applied while in bed in accordance with the resident's plan of care. These failures placed the residents at risk for injuries and not being provided with the appropriate, consistent, and individualized care. Findings: 1. Medical record review for Resident 14 was initiated on 1/5/26. Resident 14 was admitted to the facility on [DATE]. a. Review of Resident 14's Physician Order Report showed a physician's order dated 2/5/25, for padded side rails times two when in bed for safety due to seizure disorder. Review of Resident 14's Resident Care Plan titled Side Rail revised 11/2025 showed Resident 14 was at risk for injury due to use of side rails related to seizure activity and poor safety awareness. The Approach Plan included to apply padded side rails when Resident 14 was in bed for safety related to a diagnosis of seizure disorder and as order by the physician. Review of Resident 14's Event Note dated 12/30/25, showed Resident 14 had a forty second seizure like episode with shaking and eyes rolling upward. Resident 14 was placed on seizure precautions. On 1/6/26 at 0830 hours, an observation was conducted of Resident 14. Resident 14 was observed lying in bed. Resident 14's bed was observed with an elevated side rail attached to the right side of the bed. The right side of Resident 14's body was observed adjacent to the side rail. The side rail was observed without padding. On 1/6/26 at 0931 hours, a follow-up observation and concurrent interview was conducted with RN 1. Resident 14 was observed lying in bed. Resident 14's bed was observed with an elevated side rail attached to the right side of the bed. The right side of Resident 14's body was observed adjacent to the side rail. The side rail was observed without padding. RN 1 verified the findings and stated the side rail should be padded in accordance with Resident 14's care plan. b. Review of Resident 14's Physician Order Report showed a physician's order dated 8/30/22, to apply bilateral heel protectors while Resident 14 was in bed. Review of Resident 14's Resident Care Plan titled Skin Integrity dated 11/2025 showed Resident 14 was at risk for the development of skin breakdown due to fragile skin, incontinence, and dependence on staff for ADLs and bed mobility. The Approach Plan included the application of the bilateral heel protectors while in bed. On 1/6/26 at 0830 hours, an observation was conducted of Resident 14. Resident 14 was observed lying in his bed. Resident 14's heels were observed resting directly on the mattress. Resident 14 had no heel protectors. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/6/26 at 0931 hours, a follow-up observation and concurrent interview was conducted with RN 1. Resident 14 was observed lying in his bed. Resident 14's heel protectors were not applied and the resident's heels were observed resting directly on the mattress. RN 1 verified the findings. RN 1 stated Resident 14's heel protectors should have been applied while Resident 14 was in bed to prevent pressure injuries, in accordance with Resident 14's care plan. 2. Medical record review for Resident 22 was initiated on 1/5/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Physician Order Report showed a physician's order dated 7/16/25, to apply bilateral heel protectors while Resident 22 is in bed. Review of Resident 22's Resident Care Plan titled Actual Skin Breakdown dated 11/3/25, showed Resident 22 had a left ankle redness. The Approach Plan included to provide Resident 22 with the treatment as ordered. On 1/5/26 at 1035 hours, an observation was conducted of Resident 22. Resident 22 was observed lying on his bed. Resident 22's heels were observed resting directly on the mattress. Resident 22 had no bilateral heel protectors. On 1/5/26 at 1140 hours, a follow-up observation and concurrent interview was conducted with CNA 4. Resident 22 was observed lying on his bed. Resident 22's heel protectors were not applied and the resident's heels were observed resting directly on the mattress. CNA 4 verified the findings and stated Resident 22's heel protectors should always be applied while Resident 22 was in bed in accordance with Resident 22's care plan. 3. Review of the facility's P&P titled Care Planning revised on 8/2010 showed the purpose of care planning is to assure a coordinated and comprehensive written plan is developed based on the resident assessment and on the individual needs of the resident. Medical record review for Resident 8 was initiated on 1/8/26. Resident 8 was admitted on [DATE]. Review of Resident 8's plan of care dated 1/13/23, showed a care plan problem addressing the resident's risk for injury during seizures; and risk for seizure activity related to diagnosis of seizure disorder. Interventions in the care plan included padding both side rails. On 1/5 at 1442 and 1530 hours; 1/6 at 0817, 1020, 1320, and 1520 hours; and 1/7/26 at 0852 and 1015 hours, concurrent observation was conducted for Resident 8. During the observations, Resident 8's side rails were padded partially, leaving half of the upper rail exposed. Resident 8's upper body including the head was not protected due to the exposed upper rail. On 1/7/26 at 1020 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 8 had a history of seizures. CNA 2 stated the purpose of both padded side rails was to prevent Resident 8 from injury. CNA 2 verified Resident 8's side rails were not fully padded, the exposed railing on both sides was closest to the head, and Resident 8 could have an injury if the resident were to have a seizure. On 1/8/26 at 0845 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 2. RN 2 acknowledged Resident 8's bed rails were partially padded. RN 2 stated (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the entire side rails should be padded, and if a resident were to have a seizure the resident could have an injury. RN 2 verified Resident 8 had a care plan for padding on both side rails. On 1/12/26 at 1620 hours, an interview was conducted with the CNO/Interim CEO. The CNO/Interim CEO was shown a picture of the padded side rails for Resident 8. The CNO/Interim CEO acknowledged both side rails were exposed and not padded per Resident 8's care plan which could cause harm to the resident. Cross reference to F689, example #4.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the development of pressure injuries, for three of five sampled residents (Residents 5, 14, and 22) reviewed for pressure ulcers. * The facility failed to ensure the bilateral heel protectors were applied while Residents 5, 14, and 22 were in bed as per the physician's orders. These failures had the potential for the residents to develop pressure injuries. Findings: Review of the facility's P&P titled Skin Care Management reviewed 9/2025 showed all the residents would have a skin risk assessment completed upon admission utilizing the Braden Scale and direct observation. This assessment would create a baseline for further skin and/or wound care and minimize and/or prevent any further deterioration of tissue. Under the section, Reassessment and Documentation showed to employ prevention techniques, pressure reduction mattress, heel protectors, and turning of the residents every two hours. 1. Medical record review for Resident 14 was initiated on 1/5/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Physician's Order Report showed a physician's order dated 8/30/22, to apply bilateral heel protectors while Resident 14 was in bed. Review of Resident 14's H&P examination dated 6/22/25, showed Resident 14 had no capacity to understand and make decisions. Review of Resident 14's Resident Care Plan titled Skin Integrity dated 11/2025 showed Resident 14 was at risk for the development of skin breakdown due to fragile skin, incontinence, and dependence on staff for ADL care and bed mobility. The plan of care included the application of bilateral heel protectors while in bed. On 1/6/26 at 0830 hours, an observation of Resident 14 was conducted. Resident 14 was observed lying in his bed. Resident 14's heels were observed resting directly on the mattress. Resident 14's heel protectors were not applied. On 1/6/26 at 0931 hours, an observation and concurrent interview for Resident 14 was conducted with RN 1. Resident 14 was observed lying in bed. Resident 14's heels were observed resting directly on the mattress. Resident 14's heel protectors were not applied. RN 1 verified the findings. RN 1 stated Resident 14's heel protectors should have been applied while Resident 14 was in bed to prevent pressure injuries. Cross reference F656 #1a. 2. Medical record review for Resident 22 was initiated on 1/5/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Physician's Order Report showed a physician's order dated 7/16/25, to apply bilateral heel protectors while Resident 22 is in bed. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 22's Resident Care Plan titled Actual Skin Breakdown dated 11/3/25, showed Resident 22 had left ankle redness. The plan of care included to provide Resident 22 with treatment as ordered. Review of Resident 22's Physician's Order Report showed a physician's order dated 12/29/25, for left ankle wound treatment. The order showed to cleanse Resident 22's left ankle wound with normal saline, pat dry, apply Santyl (prescription medication used to remove dead or damaged tissue from chronic skin ulcers and severe burns) ointment, cover with dry dressing daily and as needed if soiled or dislodged for 21 days. On 1/5/26 at 1035 hours, an observation for Resident 22 was conducted. Resident 22 was observed lying in bed. Resident 22's heels were observed resting directly on the mattress. Resident 22's heel protectors were not applied. On 1/5/26 at 1140 hours, an observation and concurrent interview for Resident 22 was conducted with CNA 4. Resident 22 was observed lying in bed. Resident 22's heels were observed resting directly on the mattress. Resident 22's heel protectors were not applied. CNA 4 verified the findings. CNA 4 stated Resident 22's heel protectors should always be applied while Resident 22 was in bed, in accordance with the physician's order. Cross reference F656 #2. 3. Medical record review for Resident 5 was initiated on 1/5/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 10/13/25, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's Plan of Care showed a care plan problem dated 10/13/22, addressing Resident 5's risk for the development of skin breakdown. The interventions included to offload (suspension of the heel in the air by placing pillows under the lower leg so as not to place pressure on the Achilles tendon and the heel to prevent or heal ulcers, wounds, and other conditions) the heels when in the bed or chair, and to apply the bilateral heel protectors while in bed. Review of Resident 5's MDS assessment dated [DATE], showed Resident 5 was fully dependent on staff for rolling from left and right and Resident 5 required was at risk of developing pressure ulcers/injuries (areas of damaged skin caused by staying in one position for a long time which reduces blood flow to the area and causes the skin to die and develop a sore). Review of Resident 5's Physician's Order Report for January 2026 showed a physician's order dated 10/13/22, to apply the bilateral heel protectors while Resident 5 was in bed. On 1/5/26 at 1548 hours, Resident 5 was observed lying in bed. Resident 5 was not observed wearing the bilateral heel protectors and Resident 5's bilateral heels were observed directly on top of the mattress. On 1/7/26 at 0935 hours, Resident 5 was observed lying in bed. Resident 5's bilateral lower extremities were observed contracted and Resident 5 was not observed wearing the bilateral heel protectors. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/7/26 at 1130 hours, an interview and concurrent observation for Resident 5 was conducted with RN 3. Resident 5 was observed lying in bed and was not observed wearing the bilateral heel protectors. Resident 5 was observed with both heels on top of the mattress. RN 3 verified the above findings. RN 3 stated Resident 5 was at risk for developing pressure injuries and Resident 5 had a physician's order to apply the bilateral heels while in bed. RN 3 further stated Resident 5 should have the bilateral heel protectors when in bed. On 1/7/26 at 1504 hours, an interview was conducted with CNA 3. CNA 3 stated Resident 5 was contracted in the upper and lower extremities. When asked about Resident 5's bilateral heel protectors, CNA 3 stated Resident 5's bilateral heel protectors were not applied in the morning because Resident 5's heel protectors were soiled and were being washed. CNA 3 stated Resident 5's bilateral heels should have been offloaded with the pillows until the heel protectors were available. On 1/12/2026 at 1451 hours, an interview was conducted with the DON. The DON stated for the residents at risk for developing skin breakdown, including pressure injuries, the bilateral heel protectors should be applied as per the physician's orders. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and P&P review, the facility failed to provide RNA services per the physician's order for one of 14 final sampled residents (Resident 3). * Resident 3 did not receive RNA services per the physician's order. This failure had the potential for Resident 3's upper body contractures and range of motion (ROM) to worsen. Findings: Medical record review for Resident 3 was initiated on 1/9/26. Resident 3 was admitted to the facility on [DATE]. On 1/6/26 at 0813 hours, Resident 3 was observed with a contracture to the right hand. Review of Resident 3's care plan for actual functional limitation in range of motion dated 6/22/22, showed interventions including RNA to perform range of motion exercises as ordered by the physician. Review of Resident 3's Physician Order Report showed the following physician orders:- dated 12/3/25, RNA to provide range of motion to both upper extremities daily five times a week for 30 days; and- dated 12/18/25, RNA to provide range of motion to both lower extremities daily five times a week for 30 days. Review of the RNA schedule for December 2025 showed there was one RNA scheduled for the month and no RNA scheduled on the following dates: 12/1, 12/3, 12/5, 12/8, 12/10, 12/12, 12/14, 12/17, 12/19, 12/22, 12/24, 12/26, and 12/31/25. Review of the RNA schedule for January 2026 showed there was one RNA scheduled for the month and no RNA scheduled on the following dates: 1/2, 1/5, and 1/7/26. On 1/9/26 at 0844 hours, an interview and concurrent medical record review was conducted with RNA 1. RNA 1 stated documentation of services are done after providing care. Review of Resident 3's medical record failed to show the resident received RNA services on 12/1, 12/3 to 12/4, 12/9 to 12/11, 12/16 to 12/19, 12/24 to 12/25, and 12/31/25; and 1/2, 1/5, and 1/7/26. RNA 1 verified Resident 3 did not receive RNA services per physician's order on those dates. RNA 1 stated they were not always able to provide the services to Resident 3 since there was the only RNA providing services to all the residents on the floor. RNA 1 stated there should be two RNAs scheduled, but typically there's one RNA scheduled or no RNA's scheduled. On 1/9/26 at 1047 hours, an interview was conducted with the DSD. The DSD stated there were two RNA's to be scheduled Monday through Friday. The DSD verified there was only one RNA scheduled on some days, sometimes none, and therefore Resident 3 did not receive the RNA services per the physician's order. The DSD stated only RNAs are allowed to provide RNA services since it requires training, clearance for competency, and certification. On 1/9/26 at 1502 hours, the DON was made aware of the above findings and verified Resident 3 was not always given RNA services per physician's orders.		

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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 observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the IV access for one of one final sampled resident (Resident 5) reviewed for IV care. * The facility failed to ensure Resident 5's peripheral IV dressing on the left lower extremity was labeled with the date and initials and a care plan was developed for the use and maintenance of Resident 5's peripheral IV. In addition, the facility failed to ensure the insertion and/or removal of the peripheral IV and daily assessment of the peripheral IV site were documented. These failures had the potential to delay the identification of catheter related complications for Resident 5. Findings: Review of the facility's P&P titled Intravenous Therapy reviewed 9/2023 under the section for Therapy, General Guidelines - IV Initiation and Maintenance showed to:- initiate an IV using the aseptic technique,- cover the IV site with a transparent occlusive dressing, to flush the IV site every 12 hours and after each use with two milliliters of normal saline, and- change the IV site every 96 hours (unless ordered otherwise by the physician). Further review of the facility's P&P, under the section for Documentation on the Nursing Flowsheet showed to document:- all IV attempts and when an IV was started or changed, and- all IV sites, to document daily, the site, type/gauge, assessment, and insertion date. On 1/5/26 at 1543 hours, Resident 5 was observed lying in bed with a peripheral IV in Resident 5's left lower leg. The peripheral IV's transparent dressing was observed undated. Medical record review for Resident 5 was initiated on 1/5/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P dated 10/13/25, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's plan of care failed to show a care plan problem was developed to address the use and maintenance of Resident 5's left lower extremity peripheral IV. Review of Resident 5's medical record failed to show any documentation of the insertion and assessment of Resident 5's peripheral IV site in the left lower extremity. On 1/5/26 at 1548 hours, an interview and concurrent observation of Resident 5 was conducted with LVN 2. LVN 2 verified Resident 5's peripheral IV dressing was not labeled with the date and the licensed nurse's initials. When asked about Resident 5's peripheral IV, LVN 2 stated she did not know when Resident 5's left lower leg peripheral IV line was placed. On 1/5/26 at 1625 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 stated Resident 5's left lower leg peripheral IV was started on 1/3/26, when the physician initially wanted Resident 5 on an antibiotics for leukocytosis. RN 1 stated Resident 5's physician decided to wait for the culture and sensitivity results before prescribing the antibiotics. RN 1 further stated Resident 5's peripheral IV was kept because it was hard to start a peripheral IV on Resident 5. On 1/7/26 at 0924 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 3. RN 3 stated for the residents with peripheral IVs, the peripheral IV dressings should be labeled with the date and the initials of the RN who applied the dressing. RN 3 stated on every shift, the RN was responsible for the assessment of the peripheral IV, to assess the site for patency, any signs and symptoms of infection, phlebitis and infiltration into surrounding soft tissue. RN 3 stated for the residents with a peripheral IV, there should be a care plan developed for the use and monitoring of the peripheral IV. RN 3 reviewed Resident 5's medical record and verified the above findings. RN 3 verified there was no documentation of when Resident 5's left lower leg peripheral IV was initiated, there were no documentation of the assessment of the peripheral IV every shift by the registered nurse and there was no care plan developed for Resident 5's peripheral IV. On 1/12/26 at 1541 hours, an interview was conducted with the DON. The DON stated after the insertion of the peripheral IV, the licensed nurse should document the location and assessment of the IV site in the resident's medical record. The DON stated the peripheral IV site should be assessed for signs and symptoms of infection, infiltration, or swelling and documented every shift, and as needed. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings.		

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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, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below five percent. The facility's medication error rate was 7.69% * Resident 8 had a physician's order for amlodipine 5 mg daily via GT for hypertension (high BP). The order showed to hold the medication if Resident 8's SBP was less than 100 mmHg. However, the licensed nurse held the medication when Resident 8's SBP was not less than 100 mmHg. This failure to administer the antihypertensive medication in accordance with the physician's order had the potential to result in negative health outcomes. * Resident 8 had a physician's order for liquid potassium chloride 10 mEq daily via GT for hypokalemia. The licensed nurse failed to dilute the potassium chloride prior to administering the medication, in accordance with the label affixed to the medication. This failure to dilute liquid potassium chloride had the potential to cause severe stomach irritation and inhibit proper absorption. Findings: Review of the facility's P&P titled Medication Administration revised 10/2023 showed the medications given to the residents will be safely administered. Medication preparation included obtaining a unit dose (of medication) from the resident medication cassette or pharmacy and verifying for accuracy. Medication preparation included having checked and documented necessary vital signs before administering medications. Medical record review for Resident 8 was initiated on 1/5/26. Resident 8 was admitted to the facility on [DATE]. On 1/12/26 at 0823 hours, a medication administration observation for Resident 8, interview, and concurrent medical record review was conducted with LVN 9. LVN 9 prepared and administered Resident 8's morning medications. LVN 9 obtained 7.5 ml (equal to 10 mEq) of liquid potassium chloride from a bulk bottle. LVN 9 then administered the 7.5 ml of liquid potassium chloride to Resident 8. LVN 9 stated Resident 8's BP was obtained at 0800 hours, and was measured at 100/75 mmHg. LVN 9 stated she held Resident 8's morning dose of amlodipine 5 mg via GT for hypertension, due to Resident 8's systolic blood pressure of 100 mmHg. a. Review of Resident 8's Clinical Summary Report showed a physician's order dated 4/8/25, for amlodipine 5 mg daily via GT for hypertension. Hold medication for SBP less than 100 mmHg. Review of Resident 8's Vitals Flow Sheet (undated) showed Resident 8's BP was measured at 100/75 mmHg on 1/12/26 at 0807 hours. LVN 9 verified Resident 8's order for amlodipine 5 mgs daily via GT for hypertension was to be held if Resident 8's SBP was less than 100 mmHg. LVN 9 verified Resident 8's SBP was not measured as less than 100 mmHg this morning. LVN 9 stated she made an error having held the medication. LVN 9 stated she would return to Resident 8's room and administer the medication in accordance with the physician's order. b. Review of Resident 8's Clinical Summary Report showed a physician's order dated 3/25/24, for potassium chloride 10 mEq daily via GT for hypokalemia. Review of Resident 8's bulk bottle of potassium chloride liquid label showed to administer 7.5 ml (10 mEq) of potassium chloride once daily. The bottle was labeled HIGH ALERT, dilute prior to administration. LVN 9 verified the label attached to Resident 8's bulk bottle of potassium chloride liquid, showed to administer 7.5 ml (10 mEq) of potassium chloride once daily. LVN 9 verified Resident 8's bulk potassium chloride liquid bottle was labeled HIGH ALERT, dilute prior to administration. LVN 9 verified she failed to dilute the 7.5 ml (10 mEq) of liquid potassium chloride she administered to Resident 8.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and facility P&P review, the facility failed to ensure two of four medication carts were clean. * Medication Carts A and B were observed with unclean containers. The unclean containers contained lancets, alcohol pads, insulin syringes, and a pill splitter. This failure to maintain the medication carts in a sanitary condition posed the risk for negative residents health outcomes. Findings: Review of the facility's P&P titled Infection Control Program and Surveillance dated 9/2025 showed the facility has developed and maintains an Infection Control Program that provides a safe, sanitary, and comfortable environment to help prevent the development and transmission of infections. 1. On 1/8/26 at 1245 hours, an inspection of Medication Cart A was conducted with LVN 5. The top drawer of Medication Cart A contained two plastic containers. The two plastic containers contained alcohol pads, lancets, and insulin syringes. The bottom of the containers were observed with brownish/blackish stains and an unknown brownish/blackish substance. LVN 5 verified the findings. LVN 5 stated the containers needed to be cleaned for infection control as the alcohol pads, lancets, and insulin syringes were items used to provide resident care. 2. On 1/8/26 at 1250 hours, an inspection of Medication Cart B was conducted with LVN 8. The top drawer of Medication Cart B contained two plastic containers. The two plastic containers contained alcohol pads, lancets, insulin syringes, and a pill splitter. The bottom of the containers were observed with brownish/blackish stains and an unknown brownish/blackish substance. LVN 8 verified the findings. LVN 8 stated the containers needed to be cleaned for infection control.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation requirements were met in the kitchen. * The facility failed to ensure the proper labeling of food in the freezer. * The facility failed to ensure the kitchen utensils and equipment were stored or kept in sanitary conditions. * The facility failed to ensure the kitchen utensils were in good condition. * The facility failed to ensure the kitchen utensils were air-dried. * The facility failed to ensure the item in the kitchen was discarded after the use-by date. * The facility failed to ensure proper sanitary condition of the ice machine. These failures had the potential for exposure to food-borne illnesses for a medically vulnerable population. Findings: 1. According to FDA Food Code 2022, Section 3-501.17, Ready-To-Eat, Time/Temperature Control for Safety Food, Date Marking (undated), showed date marking requirements apply to containers of processed food that have been opened and to food prepared, if held for more than 24 hours, by marking the date or day the original container is opened with a procedure to discard the food on or before the last date by which the food must be consumed. On 1/5/26 at 0819 hours, an initial tour of the kitchen was conducted with RD 1 and the Dietary Assistant. There was an opened bag of chocolate covered pastries stored inside of the walk-in freezer. The bag was not labeled with an open date. RD 1 verified the findings. The Dietary Assistant stated the bag of frozen pastries was a personal food item from the dietary staff and should not have been stored inside the freezer. 2. According to FDA Food Code 2022, 4-602.13, Non-Food Contact Surfaces (undated) showed the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. On 1/5/26 at 0819 hours, an initial tour of the kitchen was conducted with RD 1. The following was observed:- one bin containing clean kitchen utensils had debris and multiple white particles at the bottom of the bin; and- one bin containing clean kitchen utensils had greyish colored debris and a pepper packet at the bottom of the bin. RD 1 verified the above findings and stated the bins storing the clean kitchen utensils should be clean. 3. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics (undated) showed for materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be safe, durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 1/5/26 at 0819 hours, an initial tour of the kitchen was conducted with RD 1. The following was observed:- two blue-handled scoopers had discolored and chipped handles; - three black-handled and one grey-handled portion servers had melted handles; and- two spatulas were discolored, cracked, and chipped. RD 1 verified the above findings. 4. According to the USDA Food Code 2022, Section 4-901.11, Equipment and Utensils, Air-Drying Required (undated) showed items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items prevents them from drying and may allow an environment where microorganism can begin to grow. Review of the facility's P&P titled Dish Machine Procedures revised 6/2023 showed to allow the flatware to air dry. On 1/5/26 at 0819 hours, during the initial tour of the kitchen with RD 1, two grey handled scoopers were observed stored wet inside a bin with multiple clean kitchen utensils. RD 1 verified the above findings. 5. Review of the facility's P&P titled Food Storage reviewed 6/2023 showed food supplies shall be continuously checked for freshness and expiration date. Any expired food items shall be discarded immediately and the manager/supervisor shall be notified. On 1/5/26 at hours, an initial tour of the kitchen was conducted with RD 1. The following was observed:- one bin labeled lentil had a use by (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER South Coast Global Medical Center D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 2701 South Bristol Street Santa Ana, CA 92704	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date of 12/30/25; and- one bin labeled jasmine rice was not labeled with the use-by date. RD 1 verified the above findings and stated the bins should be labeled with the use-by date to determine when the items should be discarded, and should be discarded timely. 6. Review of the facility's P&P titled Ice Machine Maintenance reviewed 8/2023 showed ice machines shall be scheduled for regular maintenance at intervals not exceeding semi-annual. Ice machines shall be visually inspected monthly for cleanliness and proper operation. Review of the Hoshizaki Model DCM-300AH Cubelet Icemaker/Dispenser Instruction Manual issued 3/25/20, showed under Cleaning and Sanitizing Instructions, the icemaker must be cleaned and sanitized at least twice a year. More frequent cleaning and sanitizing may be required in some conditions. On 1/8/26 at 1410 hours, an interview was conducted with RD 2. RD 2 stated for the residents in the Sub-Acute unit who had an order for ice chips, the ice chips were obtained from the ice machine located in the cafeteria. On 1/8/26 at 1415 hours, an inspection of the Hoshizaki ice machine located in the cafeteria and a concurrent interview was conducted with RD 2 and the Director of the Facility. The ice machine cover was removed to reveal inner compartment. The inner shoot was observed with blackish-brown colored build-up surrounding the exit spout of the ice compartment. RD 2 verified the findings and stated ice should be served clean. A paper towel was used to wipe the build- up and the paper towel was observed with blackish- brown colored substance on the paper towel. The Director of the Facility verified the finding and was asked to describe what it was. The Director of the Facility stated it was dark, black-brown build-up. a. Medical record review for Resident 18 was initiated on 1/5/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Active Order Requisition dated 1/8/26, showed a physician's order dated 1/6/26, for ice chips only. To give one to three ounces of ice chips daily for oral gratification. On 1/8/26 at 1524 hours, an interview was conducted with LVN 4. LVN 4 stated Resident 18 had GT feeding, however, the resident could have ice chips when he requested. LVN 4 stated she obtained the ice from the ice machine in the cafeteria. b. Medical record review for Resident 23 was initiated on 1/8/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Order Report for January 2026 showed a physician's order dated 10/21/25, for Resident 23 to be NPO (nothing by mouth) except for ice chips for oral gratifications. On 1/8/26 at 1527 hours, an interview was conducted with LVN 5. LVN 5 stated the ice chips were provided to Resident 23 twice a day. On 1/12/26 at 1510 hours, an interview was conducted with the DON and RD 2. The DON and RD 2 were informed and acknowledged the above findings.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the medical record for one of 14 final sampled residents (Resident 5) was accurate. * The facility failed to ensure Resident 5's POLST was complete. This failure had the potential for the resident's care needs not being met as the medical information was inaccurate. Findings: Medical record review for Resident 5 was initiated on 1/5/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Advance Directive Acknowledgement dated 10/24/22, showed Resident 5's responsible party selected yes to formulating an advance directive. Review of Resident 5's POLST dated 10/24/22, showed Resident 5's responsible party signed on the POLST on 10/24/22. Further review of the POLST showed under section D, showed the information regarding the advance directive was left blank. Review of Resident 5's H&P examination dated 10/13/25, showed Resident 5 had no capacity to understand and make decisions. Review of Resident 5's MDS assessment dated [DATE], showed under section S9040H, Resident 5 was coded for no advance directive. Review of Resident 5's medical record failed to show the documentation the discrepancy regarding Resident 5's advance directive was clarified. On 1/7/26 at 0854 hours, an interview and concurrent medical record review for Resident 5 was conducted with the Social Service Worker. The Social Service Worker stated Resident 5 had no advance directive. The Social Service Worker reviewed Resident 5's medical records and verified the above findings. The Social Service Worker stated the POLST should be complete and accurate. The Social Service Worker stated she spoke with Resident 5's responsible party and verified Resident 5 had no advance directive and Resident 5's responsible party selected yes in error. The Social Service Worker was unable to find documentation to show if she clarified it with Resident 5's responsible party. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings.		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the MDS assessment was completed accurately for one of 14 final sampled residents (Resident 18). * The facility failed to ensure the section for Resident 18's gradual dose reduction (GDR) was coded correctly in the resident's quarterly MDS assessment. This failure had the potential risk of the resident not receiving the individualized plan of care based on the resident's specific needs. Findings: Medical record review for Resident 18 was initiated on 1/5/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's MDS assessment dated [DATE], showed Resident 18 had a diagnosis of psychotic disorder and Resident 18 was taking the antipsychotic medication. Under the section for Medications showed Resident 18 received the antipsychotic medication on a routine basis since admission to the facility. Further review of the MDS showed a GDR had not been attempted, and a GDR had been documented by the physician as clinically contraindicated on 9/30/25. Review of Resident 18's Progress Notes dated 9/30/25, showed a physician's progress note titled GDR Meeting. The physician's note showed the documentation Resident 18 was due for GDR, to decrease the Seroquel (antipsychotic medication) medication to 100 mg BID. Further review of Resident 18's Physician's Progress Notes failed to show the documentation by the physician, the GDR was clinically contraindicated. Review of Resident 18's Clinical Summary Report dated 11/25/25, showed an active physician's order to administer Seroquel 150 mg via GT every 12 hours for psychosis as manifested by striking out to staff. On 1/7/26 at 1447 hours, an interview and concurrent medical record review for Resident 18 was conducted with the MDS Coordinator. When asked about the physician's documentation showing the GDR for the Seroquel medication was contraindicated, the MDS Coordinator was unable to find the documentation. The MDS Coordinator verified Resident 18's MDS was coded inaccurately. On 1/12/26 at 1630 hours, an interview was conducted with the CNO, DON, DSD, and IP. The CNO, DON, DSD, and IP were informed and acknowledged the above findings.		

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was revised for one of 14 final sampled residents (Resident 7). * The facility failed to ensure Resident 7's comprehensive care plan was revised to reflect a physician's order for changing the ventilator circuit-set up every two weeks and as needed if visibly soiled or malfunctioning. This failure posed the resident at risk for not being provided with the appropriate, consistent, and individualized care. Findings: Medical record review for Resident 7 was initiated on 1/7/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's plan of care showed a care plan dated 4/18/22, for potential alteration in gas exchange related to ineffective airway clearance and risk for infection related to long term trach tube status and colonization. The approach plan included to change the ventilator circuit set-up as needed when visibly soiled or malfunctioning. Review of Resident 7's Physician Order Report showed a physician's order dated 5/31/23, to change the vent circuit set up every two weeks and as needed if visibly soiled or malfunctioning. On 1/7/26 at 1348 hours, an interview and concurrent medical record review was conducted with RT 1. RT 1 verified the current physician's order for changing the vent circuit set up was every two weeks and as needed if visibly soiled or malfunctioning. On 1/12/25 at 1521 hours, an interview was conducted with the DON. The DON was made aware of the above findings. The DON stated the importance of revising the care plan was to ensure the goals were being met, interventions were being implemented, and monitoring the interventions for the purpose of needing to change them if not meeting the goal.		