STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Ranch Skilled Nursing & Rehabilitation Cente	1550 Silveira Parkway San Rafael, CA 94903

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 0657 Level of Harm - Minimal harm or potential for actual 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 and record review, the facility failed to develop and implement a care plan for three of five sampled residents (Resident 2, Resident 3, and Resident 5) when:1. Resident 2's care plan for intravenous (IV) therapy (a medical process that administers fluids, medications and nutrients directly into a person's vein) was initiated seven days after the start of his IV therapy, and;2. Resident 3 and Resident 5's IV therapy was not care planned. These failures placed Resident 2, Resident 3, and Resident 5 at risk for unmet care needs and inadequate care planning. Cross reference F684.1. A review of Resident 2's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included muscle wasting and atrophy (wasting or loss of muscle tissue), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 3/20/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 10, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 2's order summary report indicated the following order with a start date of 3/24/25, Normal saline [NS (sodium chloride)- a saltwater solution] flush intravenous [into the vein] solution 0.9% (Sodium Chloride flush). Use two (2) liter [L- a unit measure of capacity] intravenously one time a day for 40cc/hr [cubic centimeters per hour- a unit used in medical settings to measure the rate of IV fluid infusion]. Resident 2's order summary report also indicated the following order with a start date of 3/24/25, Peripheral IV [PIV- a short, flexible catheter inserted into a small peripheral vein] site location: R [right] arm, for hydration. [Which indicated Resident 2 had an IV.] A review of Resident 2 's Medication Administration Record (MAR) dated March 2026 indicated the order for NS was administered on 3/24/26, and 3/27-3/28/26. A review of Resident 2's care plan report indicated, IV therapy. At risk for IV therapy complication(s): Phlebitis [inflammation of a vein, often causing pain], Extravasation [leakage of IV medications into surrounding tissue rather than the vein, causing pain], Air Embolism [a life-threatening medical emergency occurring when air bubbles enter veins or arteries]. At risk for adverse drug reaction. This care plan was not initiated until 3/30/26. 2. A review of Resident 3's admission record indicated she was admitted to the facility in February 2026 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness) of left lower limb and asthma (inflammatory disease of the airway causing breathing difficulties). A review of Resident 3's MDS dated [DATE] indicated her BIMS score was 15, which indicated her cognition was intact. A review of Resident 3's order summary report indicated the following order with a start date of 3/13/26, please place a peripheral IV ASAP [as soon as possible] one time only for IV antibiotics [a medication used to treat or prevent bacterial infections] for one (1) day. A review of Resident 3's progress note type, Health Status Note, dated 3/14/26 at 8:07 a.m. indicated, Patient had a new PIV [peripheral IV] line to right wrist.for Ceftriaxone [IV antibiotic]. A review of Resident 3's care plan report with a print date of 4/2/26, (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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated no evidence that an IV therapy care plan was initiated. A review of Resident 5's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included sepsis (a life-threatening blood infection) and acute pyelonephritis (a serious bacterial infection of the kidneys [organs that filters blood to remove waste, excess fluid and toxins from the body]). A review of Resident 5's MDS dated [DATE] indicated his BIMS score was eight, which indicated his cognition was moderately impaired. A review of Resident 5's order summary report indicated the following order with a start date of 3/25/26 and 3/31/26, Dextrose-Sodium Chloride IV Solution 5-0.9% [Dextrose with Sodium Chloride: D5NS- a fluid that contains 5% dextrose (sugar) and 0.9% NS]. Use two (2) liter intravenously one time only for dehydration for two (2) days 75 cc/hr. A review of Resident 5's progress note type, Health Status Note, dated 3/26/26 at 3:03 p.m. indicated, Pt [patient] IV started on their right upper forearm. A review of Resident 5's care plan report with a print date of 4/15/26, indicated no evidence that an IV therapy care plan was initiated. During an interview on 4/2/26 at 2:12 p.m., Licensed Nurse 1 (LN 1) confirmed residents that received IV therapy should have the IV therapy care planned. LN 1 stated care plans were important because they provided continuity of care. LN 1 further stated, It gives a lay out of who we are working with and how to adjust their plans of care if needed. During an interview and concurrent record review on 4/2/26 at 4:08 p.m., the Director of Nursing (DON) stated a resident's care plan determined the plan of care. The DON further stated the care plans identified active diagnosis and what the nursing goals and interventions were for it. The DON stated a resident on IV therapy required a care plan because it identified the indication, the risk and how to minimize the risks through the interventions. The DON reviewed Resident 2's care plan report and confirmed she expected his care plan for IV therapy to be initiated on 3/23/26, when his IV therapy started. The DON reviewed Resident 3's care plan report and confirmed no care plan was initiated for IV therapy. During an interview on 4/15/26 at 2:19 p.m., the DON stated she reviewed Resident 5's care plan and she confirmed that no care plan was initiated for his IV therapy. A review of the facility's policy and procedures (P&P) titled, Care Plans, revised 2022, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan.describes the services that are to be furnished.reflects currently recognized standards of practice for problem areas and conditions.Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's condition change. A review of the facility's P&P titled, Resident Quality of Care and Quality of Life, revised 2025, indicated, Resident Care Plans.Individualized, resident-centered care plans are based on comprehensive and ongoing assessments.Care plans are appropriate for the resident and include reasonable objectives and timetables. A review of the facility's document titled, Charge Nurse, dated 2003, indicated, Review care plans daily to ensure that appropriate care is being rendered.Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide services in accordance with professional standards of practice for a census of 71 residents when: 1.A Licensed Vocational Nurse (a licensed nurse responsible for rendering basic nursing care) provided nursing services outside of her scope of practice (a defined range of responsibilities and procedures that a licensed professional is legally permitted to perform) when she provided IV therapy to facility residents without IV certification, and; 2. The facility did not maintain accurate training documentation. These failures posed a potential risk to resident health and safety by compromising adherence to professional nursing standards and by impairing the facility's ability to ensure staff competence through accurate training documentation. Cross reference F684 and F842.1. A review of Resident 2's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included muscle wasting and atrophy (wasting or loss of muscle tissue), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 3/20/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 10, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 2's order summary report dated 4/2/26 indicated:Start date 3/24/26: Peripheral IV (PIV - a short, flexible catheter inserted into a small peripheral vein) intravenous (IV- into the vein) flush (positive pressure technique) with normal saline (NS- a saltwater solution) 5 ML (milliliter, a unit of volume) before and after medications. Two times a day. Start date 3/24/26: PIV site location: R [right] arm, for hydration. [Which indicated Resident 2 had an IV.]A review of Resident 2's IV Administration Record dated 3/1/26 - 3/31/26 indicated the physician order to flush the PIV with NS 5 ML before and after medications two times a day was documented as completed by Licensed Nurse 3 (LN 3, a Licensed Vocational Nurse) on 3/24/26, 3/29/26, and 3/31/26, evening shift (3 - 11:30 p.m.) at 9 p.m. A review of a facility provided document titled, Nursing Staffing Assignment and Sign-In Sheet, dated 3/24/26, indicated the evening shift Registered Nurse (RN) had called off. [Which indicated there was no RN on duty to cover the evening shift for residents that required IV therapy (a medical process that administers fluids, medications and nutrients directly into a person's vein)]. A review of Resident 3's admission record indicated she was admitted to the facility in February 2026 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness) of left lower limb and asthma (inflammatory disease of the airway causing breathing difficulties). A review of Resident 3's MDS dated [DATE] indicated her BIMS score was 15, which indicated her cognition was intact. A review of Resident 3's order summary report dated 4/2/26 indicated: Start date 3/17/26: Change primary intermittent IV tubing (a tubing administration set to deliver IV fluids [IVF]) every 24 hours. Every evening shift. Start date 3/17/26: PIV cap change after each use. Every evening shift. Start date 3/17/26: PIV flush (positive pressure technique] with NS 5 ML before and after medications. Every day and evening shift.A review of Resident 3's IV Administration Record dated 3/1/26 - 3/31/26 indicated the physician order to change the primary intermittent IV tubing every evening shift; change PIV cap every evening shift; and to flush the PIV with NS 5 ML before and after medication two times a day was documented as completed by LN 3 on 3/20/26, evening shift. During an interview on 4/1/26 at 1:15 p.m., Resident 3 stated LN 3 administered her IV antibiotics (a medication used to treat or prevent bacterial infections). Resident 3 further stated LN 3 changed the IV tubing and flushed the IV line when IV care was provided. During an interview on 4/2/26 at 3:10 p.m., LN 2 stated, As a [Licensed Vocational Nurse], if you do not have an IV certification, you should not be managing anything with the IV. During an interview on 4/2/26 at 4:08 p.m., the Director of (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON) stated [Licensed Vocational Nurses] should not provide IV therapy if they were not IV certified. The DON further stated in doing so, the [Licensed Vocational Nurses] practiced outside of their scope of practice. The DON stated if nursing staff (Licensed Vocational Nurse and/or RN) practiced outside of their scope of practice, it could compromise resident safety. The DON further stated nursing staff that practiced outside of their scope were not in compliance with the Board (Board of Nursing), the State, or CMS (Center for Medicare and Medicaid Services) regulations. During a phone interview on 4/15/26 at 12:24 p.m., LN 3 confirmed she was a Licensed Vocational Nurse and was not IV certified. LN 3 stated she could not provide IV therapy because it was outside of her scope of practice. LN 3 stated she was not allowed to change the IV tubing, the caps, or flush the IV line. LN 3 further verified she was not allowed to start IVF or antibiotics. During an interview and concurrent record review on 4/15/26 at 2:19 p.m., the DON stated that when a Licensed Vocational Nurse was assigned to a resident that required IV therapy, the IV requirements were expected to be handed off to the RN on duty. The DON stated she expected the RN to assume responsibility for the administration, documentation and monitoring of the IV therapy. The DON confirmed LN 3 was not IV certified and did not meet training requirements to perform IV therapy. The DON reviewed the facility provided document titled, Nursing Staffing Assignment and Sign-In Sheet, dated 3/24/26, and confirmed there was no RN that worked the evening shift. The DON stated, I could have stayed later to assist with the IV, but I don't recall being asked to stay and assist. The DON reviewed LN 3's documentation on Resident 2's IV administration record dated 3/24/26, 3/29/26, and 3/31/26 and confirmed based on LN 3's documentation, she completed the tasks. The DON reviewed LN 3's documentation on Resident 3's IV administration record dated 3/20/26 and confirmed based on LN 3's documentation, she completed the tasks. Subsequently, the Administrator (ADM) joined the interview and confirmed that if a Licensed Vocational Nurse performed skills outside of his/her scope of practice, it was an issue of concern. The ADM further stated he did not believe that to be the case, but that the documentation would show otherwise. 2. A review of a facility provided document titled, ON DUTY: In-Service Compliance Class Attendance Record, dated 1/7/26, indicated the class covered standards of safe medical administration. The document indicated the in-service was conducted by DON 2. The document indicated the topics covered included: best practices for safe medication administration, error reduction and timely and accurate documentation. The document was signed by 16 nurse staff and included their wet signatures (a physical signature made by hand using pen or pencil on paper). The document was signed by the instructor [DON 2]. A review of a facility provided document titled, ON DUTY: In-Service Compliance Class Attendance Record, dated 2/25/26, indicated the class covered the prevention of medication errors. The document indicated the in-service was conducted the DON. The document indicated the topics covered included: covering all routes- PO (by mouth), SQ (subcutaneous- applied under the skin), IM (intramuscular- applied in the muscle), IV, enteral (administering nutrients or medications directly into the gastrointestinal tract [esophagus, stomach, and intestines]), intranasal (applied into the nose), optic (applied into the eye) and otic (applied into the ear). The document had the same exact 16 nurse staff wet signatures, and the signatures were documented in the same staff order as the in-service compliance class attendance record conducted on 1/7/26. Visually, this document was an exact copy of the, ON DUTY: In-Service Compliance Class Attendance Record, dated 1/07/26, except with different trainings listed. The document was signed by the instructor [DON]. During a phone interview on 4/16/26 at 1:02 p.m., the DON and Administrator (ADM) stated they could not explain the duplicate in-service compliance class attendance records dated 1/7/26 and 2/25/26. The DON and ADM confirmed the in-service classes were conducted on different dates, by different instructors, and included different topics. The DON and ADM confirmed that the attendance record sign-in sheet from 2/25/26 had the same wet signatures of staff and was in the same order as signed on the attendance record sign-in sheet from 1/07/26. A review of the facility's policy and procedures titled, Staffing, Sufficient and Competent Nursing, revised 2025, indicated, The facility provides sufficient numbers of nursing staff with the appropriate skills and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment.All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law.Licensed staff must demonstrate the skills and techniques necessary to care for residents needs including.Nursing skills consistent with scope of practice.Competency requirements and training for nursing staff are established and monitored by nursing leadership. A review of the facility's document titled, Charge Nurse, dated 2003, indicated, Ensure that direct nursing care be provided by a licensed nurse, a certified nursing assistant, and/or a nurse aide trainee qualified to perform the procedure. A review of the facility's document titled, Preventing Medication Errors: Mastering the Rights of Medication Administration Across All Routes, no date, indicated, Stay within scope of practice- know what your license and facility policy allow (e.g. [example], IV pushes is RN-only).

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide quality of care for three of five sampled residents (Resident 2, Resident 3, and Resident 5) when: 1. A peripheral venous catheter (PIVC- a short, flexible catheter inserted into a small peripheral vein, also known as, peripheral intravenous [PIV] line) was inserted into Resident 2 and Resident 5 without a physician's order, 2. No order was obtained for the removal of the PIVC and the removal of the PIVC was not documented for Resident 2, Resident 3 and Resident 5, and;3. Resident 2, Resident 3, and Resident 5's physician orders were not followed. These failures increased Resident 2, Resident 3, and Resident 5's risk for complications related to intravenous (IV) therapy (a medical process that administers fluids, medications and nutrients directly into a person's vein), infection, and compromised quality of care. Cross reference F657 and F842.1. A review of Resident 2's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included muscle wasting and atrophy (wasting or loss of muscle tissue), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 3/20/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 10, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 2's order summary report dated 4/2/26 indicated:Start date 3/24/26: Normal saline (NS [sodium chloride]- a saltwater solution) flush intravenous (into the vein) solution 0.9% (Sodium Chloride flush). Use two (2) liter (L- a unit measure of capacity) IV one time a day for 40 cc/hr (cubic centimeters per hour- a unit used in medical settings to measure the rate of IV fluid infusion). [End date not indicated.],Start date 3/30/26: Dextrose-Sodium Chloride IV Solution 5-0.9% (Dextrose with Sodium Chloride: D5NS- a fluid that contains 5% dextrose [sugar] and 0.9% NS). Use two (2) liter intravenously one time only for dehydration for three (3) days 40 cc/hr. End date dated 4/2/26, Start date 3/24/26: Monitor IV site every shift for signs and symptoms (s/s) of complications- Infiltration (when medications or fluids leak into the soft tissue instead of the vein), Phlebitis (inflammation of the vein, often causing pain), Hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel), Infection. Every shift. [End date not indicated.],Start date 3/24/26: PIV flush (positive pressure technique) with NS 5 ML (milliliter, a unit of volume) before and after medications. Two times a day. [End date not indicated.],Start date 3/24/26: PIV site location: R [right] arm, for hydration. [Which indicated Resident 2 had an IV. End date not indicated.],No evidence of a physician's order to insert a PIVC, and;No evidence of a physician's order to remove the PIVC after the completion of IV therapy.A review of Resident 5's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included sepsis (a life-threatening blood infection) and acute pyelonephritis (a serious bacterial infection of the kidneys [organs that filters blood to remove waste, excess fluid and toxins from the body]). A review of Resident 5's MDS dated [DATE] indicated his BIMS score was eight, which indicated his cognition was moderately impaired. A review of Resident 5's order summary report dated 4/16/26 indicated: Start date 3/25/26: D5NS. Use two (2) liters IV one time only for hydration for two (2) days 75 cc/hr. End date dated 3/27/25,Start date 3/31/26: D5NS. Use two (2) liters IV one time only for hydration for two (2) days 75 cc/hr. End date dated 4/2/26,Start date 3/26/26 and 4/1/26: PIV flush (positive pressure technique) with NS 5 ML before and after medications. Every shift. [End date not indicated.],Start date 3/26/26: PIV cap change after each use. Every shift. [End date not indicated.],Start date 3/26/26 and 4/1/26: Monitor IV site every shift for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. [End date not indicated.],Start date 4/1/26: PIV site location: R [right] arm, for hydration. [Which indicated (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 5 had an IV. End date not indicated.],No evidence of a physician's order to insert a PIVC, and;No evidence of a physician's order to remove the PIVC after the completion of IV therapy.A review of Resident 5's progress notes titled, Health Status Note, dated 3/26/26 at 3:03 p.m., indicated, Pt [patient] IV started on their right upper forearm. 2. A review of Resident 3's admission record indicated she was admitted to the facility in February 2026 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness) of left lower limb and asthma (inflammatory disease of the airway causing breathing difficulties). A review of Resident 3's MDS dated [DATE] indicated her BIMS score was 15, which indicated her cognition was intact. A review of Resident 3's order summary report dated 4/2/26 indicated: Start date 3/15/26: Ceftriaxone (an antibiotic used to treat bacterial infections) sodium solution reconstituted (NS is added to the antibiotic to form a solution) 1 GM (gram- a unit of mass). Use one (1) gram IV every 24 hours for acute exacerbation of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) for six (six) days. End date dated 3/21/26,Start date 3/13/26: Please place a PIV ASAP (as soon as possible) one time only for IV antibiotics for one (1) day. End date dated 3/14/26,Start date 3/16/26: Monitor IV site for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. [End date not indicated.],Start date 3/17/26: Change primary intermittent IV tubing (a tubing administration set to deliver IV fluids [IVF]) every 24 hours. Every evening shift. [End date not indicated.],Start date 3/17/26: PIV cap change after each use. Every evening shift. [End date not indicated.],Start date 3/17/26: PIV flush (positive pressure technique] with NS 5 ML before and after medications. Every day and evening shift. [End date not indicated.], and; No evidence of a physician's order to remove the PIV after the completion of IV therapy.A review of Resident 3's progress notes titled, Health Status Note, dated 3/14/26 at 8:07 a.m., indicated, Patient had a new PIV line to right wrist. A review of Resident 3's Medication Administration Record (MAR) dated 3/1/26 - 3/31/26, indicated ceftriaxone sodium solution reconstituted 1 GM was started on 3/15/26 and ended on 3/20/26. [Which indicated the order was completed.] A review of Resident 3's progress notes dated 3/1/26 - 3/31/26 indicated no evidence of when the PIVC was removed. During an interview on 4/1/26 at 1:15 p.m., Resident 3 stated her IV was removed when her antibiotic treatment was completed.A review of Resident 5's MAR dated 3/1/26 - 3/31/26, indicated IVF D5NS was started on 3/26/26 and again on 3/31/26. A review of Resident 5's progress notes dated 3/25/26 - 4/3/26 indicated no evidence of when the PIVC was removed. The progress notes also did not indicate instructions to leave the PIVC site inserted. A review of Resident 2's MAR dated 3/1/26 - 3/31/25 indicated IVF NS was started on 3/24/26 and ended on 3/28/26, and that IVF D5NS was started on 3/30/26. A review of Resident 2's progress notes titled, Health Status Note, dated 3/28/26 at 2:59 p.m., indicated, .informed to leave the IV site in. A review of Resident 2's progress notes titled, Health Status Note, dated 4/2/26 at 11 p.m., indicated, IV hydration will be discontinued. A review of Resident 2's progress notes dated 4/1/26 - 4/16/26 indicated no evidence of when the PIVC was removed. 3. A review of Resident 2's IV Administration Record dated 3/1/26 - 3/31/26 indicated the following physician orders were not followed: PIV flush (positive pressure technique) with NS 5 ML before and after medications. Two times a day. The order was not completed on the day shift 3/25/26 and 3/26/26, and;Monitor IV site for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. The order was not completed on the night shift 3/24/26, the day and night shift 3/25/26, the day shift 3/26/26, and the night shift 3/30/26 and 3/31/26. A review of Resident 3's IV Administration Record dated 3/1/26 - 3/31/26 indicated the following physician orders were not followed:PIV flush (positive pressure technique] with NS 5 ML before and after medications. Every day and evening shift. The order was not completed on the day shift on 3/21/26, and;Monitor IV site for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. The order was not completed on the night shift on 3/19/26 and 3/20/26, and the day shift 3/21/26. A review of Resident 5's MAR dated 3/1/26 - 3/31/26 and 4/1/26 - 4/30/26 indicated the following physician orders were not followed: D5NS. Use two (2) liters IV one time only for hydration for two (2) days 75 cc/hr was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not completed on 3/28/26, and; D5NS. Use two (2) liters intravenously one time only for hydration for two (2) days 75 cc/hr was not completed on 4/1/26 and 4/2/26. A review of Resident 5's IV Administration dated 3/1/26 - 3/31/26 and 4/1/26 - 4/30/26 indicated the following physician orders were not followed: Monitor IV site for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. The order was not completed on the evening and night shift on 3/26/26, the day, evening and night shift on 3/27/26, the night shift on 3/28/26, the day and night shift 3/29/26 and 3/30/26, and the night shift on 3/31/26,PIV flush (positive pressure technique] with NS 5 ML before and after medications. Every shift. The order was not completed on the evening and night shift on 3/26/26, the day, evening and night shift on 3/27/26, the night shift on 3/28/26, the day and night shift 3/29/26 and 3/30/26, and the night shift on 3/31/26, PIV flush (positive pressure technique] with NS 5 ML before and after medications. Two times a day. The order was not completed the evening shift 4/2/26, and the day shift 4/3/26, and;Monitor IV site for s/s of complications- Infiltration, Phlebitis, Hematoma, Infection. Every shift. The order was not completed on the night shift 4/1/26 and 4/2/26, and the day shift 4/3/26. During an interview on 4/1/26 at 2:40 p.m., the Director of Nursing (DON) stated Resident 2's IVF order for NS 2 L at 40 cc/hr would take approximately two days to complete. The DON confirmed the end date would be two days after the order was started. The DON stated, At this rate [the rate of infusion], it's [the IVF] causing no harm as long as the IV site is being monitored. The DON further stated that she expected the nursing staff (Licensed Nurses [LN] and Registered Nurses [RN]) to monitor the IV site for redness, infiltration and for signs of infection. During an interview on 4/2/26 at 3:10 p.m., Licensed Nurse 2 (LN 2) stated a physician order was required to start or discontinue a PIV. LN 2 further stated the start or discontinuation of an PIV was expected to be documented as a progress note in the resident's medical record. During an interview and concurrent record review on 4/2/26 at 4:08 p.m., the DON reviewed Resident 2's order summary report and confirmed there was no order to start a PIV. The DON stated she expected that a physician order be obtained before the IV is started. The DON further expected the physician to be notified when IV therapy is completed to inquire if the physician wanted to order lab work, or to obtain an order to remove the IV. The DON stated communication with the physician was expected to be documented in the residents' progress notes. The DON further stated she expected the removal of the IV to be documented and to include when it was removed, by who, and the condition of the IV site to ensure no complications. The DON stated complications of IV therapy were increased risk for infection, phlebitis, and infiltration. The DON further stated the longer the IV was inserted, the risks of complications were increased. The DON reviewed Resident 2's March 2026 IV administration record and confirmed the physician order to flush the IV was not documented on 3/25/26 or 3/26/26. The DON further stated, There is no way to know if the order was followed. You can't confirm if the order was followed if it's not documented. The DON confirmed Resident 2's physician order to monitor the IV site was not completed on the night shift 3/24/26, the day and night shift 3/25/26, the day shift 3/26/26, and the night shift 3/30/26 and 3/31/26. Subsequently, the DON reviewed Resident 3's March 2026 IV administration record and confirmed the physician's order to flush the PIV was not completed on the day shift on 3/21/26. The DON further confirmed Resident 3's physician order to monitor the IV site was not completed on the night shift on 3/19/26, 3/20/26, and the day shift 3/21/26. During a phone interview on 4/15/26 at 1:15 p.m., RN 1 stated a physician order to insert an IV is required. RN 1 further stated, Because the IV is considered a medication and it is invasive [the body is entered by a needle, tube, device, or scope]. RN 1 stated an order was required before an IV was removed, and the removal was expected to be documented under a progress note in the resident's medical record. During an interview on 4/15/26 at 2:19 p.m., the DON stated, Everything you do for the patient [resident], has to have a corresponding order from the doctor so it's clear what is being provided and what needs to be done. The DON confirmed a physician order was required to insert or remove a PIVC. The DON stated she expected the PIVC insert or removal to be documented in a progress note in the resident's medical record. The DON stated she reviewed (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 2, Resident 3, and Resident 5's order summary reports and confirmed there were no orders to remove the resident's PIV catheters. The DON further stated that without an order and corresponding progress notes, you would not know when the PIV catheter was removed and if the PIV catheter was intact upon removal. The DON stated she reviewed Resident 5's medical records and confirmed that the physician orders to monitor and flush the IV were not followed during multiple shifts. Subsequently, the DON stated the facility document titled, Charge Nurse, covered the responsibilities expected by LN staff. A review of the facility's policy and procedures (P&P) titled, Resident Quality of Care and Quality of Life, revised 2025, indicated, The following quality of care/quality of life standards are recognized as high-risk areas and therefore are carefully monitored.Sufficient Staffing: Staffing is provided.with staff who have.expertise to meet the needs of residents.Medication Management: Procedures are in place to ensure accuracy and safety of administering.of medications.Resident safety: Nursing staff have the appropriate training and levels of competency to ensure resident safety. A review of the facility's P&P titled, Documentation of Medication Administration, revised 2022, indicated, Documentation of medication administration included.the condition of the venipuncture [process of puncturing the vein] or vascular access device site before and after medication administration [if administered intravenously]. A review of the facility's P&P titled, Intravenous Administration of Fluids and Electrolytes [electrically charge minerals], revised 2025, indicated, The purpose of this procedure is to provide guidelines for the safe and aseptic [free from contamination] administration of intravenous fluids and electrolytes for hydration.When continuous fluids are infusing, resident is monitored for s/s of.catheter patency [unobstructed].insertion site complications.the resident's tolerance to the procedure.Review providers order.When infusion is complete.flush catheter per protocol.Document procedure in the resident's medical record. A review of the facility's document titled, Charge Nurse, dated 2003, indicated, The primary purpose of your job position is to provide direct nursing care to the residents.to ensure that the highest degree of quality care is maintained at all times.Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care.Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures.Review MAR's for completeness of information, accuracy in the transcription of the physician's order.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 3) were free from significant medication errors when her breathing treatments and intravenous (IV- into the vein) antibiotics (a medication used to treat or prevent bacterial infections) were not administered in accordance with the physician's order. These failures decreased the facility's potential to safely administer medications and increased Resident 3's risk for compromised respiratory status and infection. A review of Resident 3's admission record indicated she was admitted to the facility in February 2026 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness) of left lower limb and asthma (inflammatory disease of the airway causing breathing difficulties). A review of Resident 3's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 2/26/26, indicated her Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 15, which indicated her cognition was intact (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 3's order summary report dated 4/2/26 indicated: Initial start date 3/13/25: ceftriaxone (an antibiotic used to treat bacterial infections) sodium solution reconstituted (NS is added to the antibiotic to form a solution) 1 GM (gram- a unit of mass). Use one (1) gram IV every 24 hours for acute exacerbation of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) for seven (7) days. (The order summary report is with multiple start dates, discontinuations, and re-orders.), and;Initial start date 2/20/26: ipratropium-albuterol inhalation solution 0.5-2.5 (a combination inhalation solution used to treat wheezing and breathlessness caused by COPD) (3) MG/3ML (milligram [mg] measures weight, and milliliters [mL] measures volume). 3 ml inhale orally (by mouth) via nebulizer (a medical device that converts liquid medication into a fine mist) every 12 hours for asthma (a chronic respiratory disease that causes breathing difficulties). (The order summary report is with multiple start dates, discontinuations, and re-orders). A review of Resident 3's Medication Administration Record (MAR) dated 3/1/26 - 3/31/26 indicated ceftriaxone sodium solution reconstituted 1 GM initial start date and time was 3/13/26 at 9 p.m. The MAR indicated on 3/13/26, the ceftriaxone medication administration was documented as a ?2' (2= No med required-Outside Parameter). Subsequently, the MAR indicated the new start date and time was 3/15/26 at 3 p.m. Resident 3's MAR indicated the ceftriaxone was administered at 7:15 p.m. on 3/15/26. A review of Resident 3's progress notes dated 3/1/26 - 3/31/26, indicated the following: Type, eMAR [medication administration record]- Medication Administration Note, dated 3/13/26 at 11:50 p.m., indicated, Ceftriaxone Sodium Solution Reconstituted 1 GM.RN [Registered Nurse] will start tomorrow 03/13 AM [morning], and; No documented evidence of why the physician's order for ceftriaxone was administered late on 3/15/26.A review of Resident 3's Respiratory MAR dated 3/1/26 - 3/31/26 indicated ipratropium-albuterol inhalation solution 0.5-2.5 (3) MG/3ML:Start date with time 2/20/26 at 8 a.m. and 8 p.m. According to the MAR, this order was discontinued on 3/5/26, Start date with time 3/5/26 at 7 a.m. and 7 p.m. Subsequently, this order was discontinued 3/11/26, and; Start date with time 3/11/26 at 7 a.m. and 7 p.m.A review of Resident 3's Medication Admin (Administration) Audit Report dated 3/1/26 - 3/31/26, indicated, based on the administration times scheduled on the respiratory MAR, the physician's order for ipratropium-albuterol inhalation solution 3 mL every 12 hours was administered late by more than one hour on 17 out of 60 opportunities. A review of Resident 3's progress notes dated 3/1/26 - 3/31/26, indicated no documented evidence why the physician's order for ipratropium-albuterol inhalation solution 3 mL every 12 hours was administered late. A review of Resident 3's care plan initiated on 2/20/26 indicated, Shortness of breath.[staff were expected to] Administer/monitor effectiveness of medications and breathing treatments as ordered by the physician, and [Resident 3] has asthma.[staff were expected to] Administer medications as ordered.A review of Resident 3's care plan initiated on 3/16/26 indicated, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Antibiotic therapy r/t [related to] medical diagnosis: COPD exacerbation.Medication: Ceftriaxone Sodium Solution 1 GM.[staff were expected to] Administer antibiotic & treatment as ordered by physician.During an interview on 4/1/26 at 1:15 p.m., Resident 3 stated she was receiving IV antibiotics to treat a lung infection. Resident 3 stated she recalled receiving her IV antibiotics late one time and she did not know why. During an interview on 4/2/26 at 2:12 p.m., Licensed Nurse 1 (LN 1) stated medication could be administered one hour before and one hour after it was ordered. LN 1 further stated if the resident did not want the medication at the ordered time, it should be documented in the resident's MAR as a progress note. LN 1 stated if the ordered medication was a maintenance medication (medication taken regularly to manage chronic, long-term conditions like asthma) it was important to give as ordered. LN 1 confirmed that a breathing treatment to treat asthma was a maintenance medication. LN 1 stated it was important that breathing treatments were administered as ordered to avoid respiratory distress (a critical condition indicating severe difficulty breathing). LN 1 stated that antibiotics had to be administered on time. LN 1 further stated if antibiotic therapy was not completed as ordered, the infection could not be treated. LN 1 stated if antibiotics were administered late, the reason for the late administration was expected to be documented in the resident's medical record, along with the physician's notification. LN 1 further stated the scheduling administration times might need to be changed. During an interview on 4/2/26 at 3:10 p.m., LN 2 stated medications could be administered one hour before and one hour after it was ordered. LN 2 stated the same applied to breathing treatments. LN 2 stated if antibiotics were administered too early or too late, the antibiotic would not act as it should to fight the infection. LN 2 further stated if an antibiotic was administered late, it was considered a delay in care because the antibiotic needed to be maintained at a certain concentration in the resident's body for the antibiotic to be effective. During an interview and concurrent record review on 4/2/26 at 4:08 p.m., the Director of Nursing (DON) stated the expectation for medication administration was that medications could be administered one hour before and one hour after the ordered administration time. The DON reviewed Resident 3's March 2026 MAR and March progress notes and stated the IV antibiotics were not administered as ordered on 3/13/26. The DON stated she expected staff to notify the physician to let them know if the facility did not have the medication. The DON further stated it was expected that the notification be documented in the resident's medical record and to include any change to the order. The DON confirmed that there was no evidence that the physician was notified about Resident 3's delay in care. The DON further stated that an antibiotic was given to prevent or treat an infection. The DON stated, It's important to give as ordered so that the antibiotic can reach the maximum therapeutic effect [the desired outcome of a medical treatment]. The DON stated she reviewed Resident 3's March medication administration audit report and confirmed the ipratropium-albuterol inhalation breathing treatment was administered late on multiple occasions. The DON stated Resident 3's scheduled breathing treatments helped with bronchodilation (a medication that opens the airways) so that she could breathe better. A review of the facility's policy and procedures (P&P) titled, Medication Administration, revised 2019, indicated, Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescriber's orders, including any required time frame.Medication administration times are determined by resident need and benefit. Factors that are considered include.enhancing optimal therapeutic effect of the medication.Medications are administered within one (1) hour of their prescribed time.A review of the facility's P&P titled, Intravenous Administration of Fluids and Electrolytes, revised 2025, indicated, Documentation.The following information should be recorded in the resident's medical record.Notification of the provider if there are any complications.A review of the facility's P&P titled, Administering Medications through a Small Volume [Handheld] Nebulizer, revised 2010, indicated, General Guideline.Follow the medication administration guidelines in the policy entitled Administering Medications.A review of the facility's document titled, Charge Nurse, dated 2003, indicated, Prepare and administer medications as ordered by the physician. A review of the facility's document titled, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Preventing Medication Errors: Mastering the Rights of Medication Administration Across All Routes, no date, indicated, The Rights of Medication Administration.Right time [usually within 30-60 minutes of the scheduled time. A review of the facility's document titled, Medication Safety Essentials: Proper Storage, Labeling, and Adhering to Physician Orders, no date, indicated, Following MD [medical doctor] Orders in Medication Administration.Timely administration: Adhere to scheduled times [usually within 30-60 minutes before/after); document exact time given.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review the facility failed to ensure accurate documentation for three out of five sampled residents (Resident 2, Resident 3, and Resident 5) when medications administered and tasked physician orders were not documented by the nurse who completed the order. This failure had the potential to compromise resident safety, monitoring, and the facility's ability to communicate essential clinical information. Cross reference F658. A review of Resident 2's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included muscle wasting and atrophy (wasting or loss of muscle tissue), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). A review of Resident 2's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 3/20/26, indicated his Brief Interview of Mental Status (BIMS-a cognition [the processes of thinking and reasoning] assessment) score was 10, which indicated his cognition was moderately impaired (a score of 1-7 indicates cognition is severely impaired, 8-12 indicates cognition is moderately impaired, and 13-15 indicates cognition is intact). A review of Resident 2's order summary report dated 4/2/26 indicated:Start date 3/24/26: Normal saline (NS [sodium chloride]- a saltwater solution) flush intravenous (into the vein) solution 0.9% (Sodium Chloride flush). Use two (2) liter [L- a unit measure of capacity] IV one time a day for 40 cc/hr [cubic centimeters per hour- a unit used in medical settings to measure the rate of IV fluid infusion), Start date 3/30/26: Dextrose-sodium chloride IV solution 5-0.9% (dextrose with sodium chloride: D5NS- a fluid that contains 5% dextrose [sugar] and 0.9% NS). Use two (2) liter intravenously one time only for dehydration for three (3) days 40 cc/hr, and;Start date 3/24/26: PIV flush (positive pressure technique) with NS 5 ML (milliliter, a unit of volume) before and after medications. Two times a day. A review of Resident 2's Medication Administration Record (MAR) dated 3/1/26 - 3/31/26 indicated the physician order to administer D5NS two (2) liter IV was documented as administered by Licensed Nurse 3 (LN 3) on 3/30/36 at 10:55 p.m.A review of Resident 2's IV Administration Record dated 3/1/26 - 3/31/26 indicated the physician orders to flush the PIV with NS 5 ML was documented as administered by LN 3 on 3/24/26 - 3/26/26 and 3/29/26 - 3/31/26. A review of Resident 2's progress notes indicated the following: Type, Health Status Note, dated 3/30/26 at 11:44 p.m., indicated, Pt [patient] on IV hydration 5% D5 NS 0.9% to run 40 cc/hr. on R forearm. First bag initiated @22:39 pm [at 11:39 p.m.]. IV line is flushed. was documented by Registered Nurse 3 (RN 3),Type, eMAR [electronic medication administration record]- Medication Administration Note, dated 3/30/26 at 11:55 p.m., indicated the physician order to administer D5NS, done by RN 3, was documented by LN 3,Type, eMAR- Medication Administration Note, dated 3/26/26 at 3:36 p.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 1, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 3/25/26 at 5:41 p.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 3, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 3/25/26 at 4:41 p.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 1, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 4/1/26 at 11:55 p.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 1, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 4/2/26 at 10:37 a.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 3, was documented by LN 3, and;Type, eMAR- Medication Administration Note, dated 4/2/26 at 10:38 a.m., indicated the physician order to flush PIV with NS 5 ML, done by RN 1, was documented by LN 3.A review of Resident 3's admission record indicated she was admitted to the facility in February 2026 with medical diagnosis which included cellulitis (a skin infection that causes swelling and redness) of left lower limb and asthma (inflammatory disease of the airway causing breathing difficulties). A review of Resident 3's MDS (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated [DATE] indicated her BIMS score was 15, which indicated her cognition was intact. A review of Resident 3's order summary report dated 4/2/26 indicated: Start date 3/15/26: ceftriaxone (an antibiotic used to treat bacterial infections) sodium solution reconstituted (NS is added to the antibiotic to form a solution) 1 GM (gram- a unit of mass). Use one (1) gram IV every 24 hours for acute exacerbation of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) for six (six) days,Start date 3/17/26: Change primary intermittent IV tubing (a tubing administration set to deliver IV fluids [IVF]) every 24 hours. Every evening shift,Start date 3/17/26: PIV cap change after each use. Every evening shift, and;Start date 3/17/26: PIV flush (positive pressure technique] with NS 5 ML before and after medications. Every day and evening shift. A review of Resident 3's MAR dated 3/1/26 - 3/31/26 indicated the physician order to administer ceftriaxone 1 GM was documented as administered by LN 3 on 3/18/26 at 4 p.m. A review of Resident 3's IV Administration Record dated 3/1/26 - 3/31/26 indicated the physician orders to change the primary intermittent IV tubing every evening shift; change PIV cap every evening shift; and to flush the PIV with NS 5 ML before and after medication two times a day was documented as administered by LN 3 on 3/17/26 - 3/20/26. A review of Resident 3's progress notes indicated the following: Type, eMAR- Medication Administration Note, dated 3/17/26 at 11:32 p.m., indicated the physician orders to change the primary intermittent IV tubing every evening shift; change PIV cap every evening shift; and to flush the PIV with NS 5 ML before and after medication two times a day, done by RN 3, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 3/18/26 at 4 p.m., indicated the physician order to administer ceftriaxone 1 GM, done by RN 3, was documented by LN 3, Type, eMAR- Medication Administration Note, dated 3/18/26 at 10:01 p.m., indicated the physician orders to change the primary intermittent IV tubing every evening shift; change PIV cap every evening shift; and to flush the PIV with NS 5 ML before and after medication two times a day, done by RN 3, was documented by LN 3, and;Type, eMAR- Medication Administration Note, dated 3/19/26 at 10:17 p.m., indicated the physician orders to change the primary intermittent IV tubing every evening shift; change PIV cap every evening shift; and to flush the PIV with NS 5 ML before and after medication two times a day, done by RN 1, was documented by LN 3.A review of Resident 5's admission record indicated he was admitted to the facility in March 2026 with medical diagnosis which included sepsis (a life-threatening blood infection) and acute pyelonephritis (a serious bacterial infection of the kidneys [organs that filters blood to remove waste, excess fluid and toxins from the body]). A review of Resident 5's MDS dated [DATE] indicated his BIMS score was eight, which indicated his cognition was moderately impaired. A review of Resident 5's order summary report dated 4/16/26 indicated: Start date 3/26/26 and 4/1/26: PIV flush (positive pressure technique) with NS 5 ML before and after medications. Every shift. A review of Resident 5's IV administration record dated 3/1/26 - 3/31/26 indicated the physician order to flush the PIV with NS 5 ML was documented as administered by LN 4 on 3/31/26. A review of Resident 5's progress note type, eMAR- Medication Administration Note, dated 3/31/26 at 2:15 p.m., indicated the physician order to flush PIV with NS 5 ML, done by Nurse Practitioner (NP), was documented by LN 4.During an interview on 4/1/26 at 1:15 p.m., Resident 3 stated LN 3 administered her IV antibiotics. Resident 3 further stated LN 3 changed the IV tubing and flushed the IV line when IV care was provided. During a phone interview on 4/13/26 at 3:27 p.m., the Director of Staff Development Consultant (DSD C) stated LN 3 was not IV certified. When asked if it was acceptable for LN 3 to document Resident 3's IV antibiotics as administered, as well as the associated IV tasks as completed in the resident's MAR, the DSD C did not directly provide an answer. The DSD C stated, I believe it was documented in error.During a phone interview on 4/15/26 at 12:24 p.m., LN 3 confirmed she was an Licensed Vocational Nurse and was not IV certified. LN 3 stated she could not provide IV therapy because it was outside of her scope of practice (a defined range of responsibilities and procedures that a licensed professional is legally permitted to perform). LN 3 stated she was not allowed to change the IV tubing, the caps, or flush the IV line. LN 3 further verified she was not allowed to start IVF or (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555595	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Ranch Skilled Nursing & Rehabilitation Cente	1550 Silveira Parkway San Rafael, CA 94903

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antibiotics. LN 3 confirmed it was not acceptable to document a medication as administered or a physician order as completed if it was administered and/or completed by someone else. LN 3 stated, I didn't do it, and I should have not done that, when referenced to the IV therapy provided and documentation of administration. LN 3 further stated the documentation was inaccurate. During an interview on 4/15/26 at 12:45 p.m., LN 5 confirmed it was not acceptable to document a medication as administered or a physician order as completed if it was administered and/or completed by someone else. LN 5 stated, The next person [nurse staff] wouldn't know if they [the resident] really got it [the medication]. LN 5 stated the documentation would be inaccurate. LN 5 further stated, Whoever provided the IV therapy should be the one documenting. During a phone interview on 4/15/26 at 1:02 p.m., LN 4 confirmed she was a Licensed Vocational Nurse and was not IV certified. LN 4 stated, It's never ok to document that you did something that you didn't actually do. It would be inaccurate or false documentation. During a phone interview on 4/15/26 at 1:15 p.m., RN 1 stated that if she provided the IV therapy, it was her responsibility as the RN to document what was completed. RN 1 further stated, The best practice is for the performing nurse to document under their own log-in, because it shows and ensures accuracy of medication administration. During an interview and concurrent record review on 4/15/26 at 2:19 p.m., the DON stated that when an LN was assigned to a resident that required IV therapy, the IV requirements were expected to be handed off to the RN on duty. The DON stated she expected the RN to assume responsibility for the administration, documentation and monitoring of the IV therapy. The DON stated, I expect the performing RN to document because they are the one's who did it. They need to take ownership and accountability to document it. The DON stated when nurse staff documented a medication as administered or a physician order as completed if it was administered and/or completed by someone else, It makes it confusing as to what actually happened and the accuracy of the documentation is in question. The DON reviewed Resident 2's MAR and eMAR progress notes dated March 2026 and confirmed the physician's order to flush the PIV with NS 5 ML was cross charted in the eMAR by LN 3 as done by RN multiple times. The DON stated, This kind of charting is not acceptable. A review of the facility's policy and procedures (P&P) titled, Documentation of Medication Administration, revised 2022, indicated, The medication administration record [MAR] is used to document all medications administered.Documentation of medication administration includes.initials, signature and title of the person administering the medication. A review of the facility's P&P titled, Medication Administration, revised 2019, indicated, The individual administering the medication documents/initials the resident's MAR.the individual administering the medication records in the resident's medical record.the signature and title of the person administering the drug. A review of the facility's P&P titled, Resident Quality of Care and Quality of Life, revised 2025, indicated, Medication Management.procedures are in place to ensure accuracy and safety of administering.medications. A review of the facility's document titled, Charge Nurse, dated 2003, indicated, Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures. A review of the facility's document titled, Preventing Medication Errors: Mastering the Rights of Medication Administration Across All Routes, no date, indicated, Preventing Medication Errors.Common causes: poor communication.