STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555730	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Regional Medical Center D/P Snf	14662 Newport Avenue Tustin, CA 92780

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 developed to reflect the individual care needs for five of nine final sampled residents (Residents 1, 5, 6, 9, and 15). * The facility failed to develop a care plan for Resident 15's use of lorazepam (antianxiety medication) and diazepam (antianxiety medication). * The facility failed to develop a care plan for Resident 1's GT feeding and use of insulin lispro (medication to lower blood sugar). * The facility failed to develop a care plan to address the use of GJ tube feeding for Resident 5. * The facility failed to develop a care plan for Resident 6's use of the duloxetine (antidepressant medication) and trazadone (antidepressant medication). * The facility failed to develop a care plan for Resident 9's use and management of the GT. These failures had the potential for the residents to not be provided with appropriate, consistent, and individualized care.Findings: Review of the facility's P&P titled Care Plan Resident (undated) showed all residents admitted to the pediatric sub-acute facility will have a plan of care developed and implemented based on the individual resident care needs. 1. Review of the facility' P&P titled Psychotropic Drugs dated 7/2025 showed the resident's plan of care shall include the specific behavior(s) for which the medication is being used, the goal of therapy, and common side effects of the medication. Medical record review for Resident 15 was initiated on 2/5/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 2/4/26, showed Resident 15 had diagnoses including spasticity. Review of Resident 15's Physician's Orders, showed the following physician's orders: - dated 9/1/25, to administer diazepam 2 mg, one tablet via GT every six hours for muscle spasms and neurological irritability; and - dated 12/17/25, to administer lorazepam 1 mg, one tablet via GT every six hours as needed for increased toning and neuro-irritability as evidenced by heart rate greater than 140 bpm. Review of Resident 15's plan of care failed to show a care plan problem was developed for Resident 15's use of diazepam and lorazepam medications. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/5/26 at 1037 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 3. RN 3 reviewed Resident 15's medical records and verified a care plan was not developed for Resident 15's use of diazepam and lorazepam medications. On 2/5/26 at 1423 hours, an interview was conducted with the CNO and RN Manager. The CNO and RN Manager were informed and acknowledged the above findings. 2. Medical record review for Resident 1 was initiated on 1/29/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 2/3/26, showed Resident 1 had diagnoses including a GT and Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control). a. On 1/29/26 at 0828 hours, during the initial tour of the facility, Resident 1 was observed lying in bed. Resident 1 was observed with Glucerna 1.2 (enteral feeding formula) infusing at 173 ml/hr via the GT. Review of Resident 1's Physician's Orders showed a physician's order dated 1/27/26, to administer Glucerna 1.2 at 173 ml/hr via the GT every four hours. Review of Resident 1's plan of care failed to show a care plan problem was developed to address Resident 1's use and management of the GT. b. Review of Resident 1's Physician's Orders showed a physician's order dated 10/31/25, to administer insulin lispro injection per sliding scale subcutaneously as needed before meals with the following medication parameters: - to inject 0 units of insulin for the blood glucose level of 60 to 150 mg/dL, - to inject 1 unit of insulin for the blood glucose level of 151 to 200 mg/dL, - to inject 2 units of insulin for the blood glucose level of 201 to 250 mg/dL, - to inject 3 units of insulin for the blood glucose level of 251 to 300 mg/dL, - to inject 4 units of insulin for the blood glucose level of 301 to 350 mg/dL, - to inject 5 units of insulin for the blood glucose level of 351 to 400 mg/dL, - to inject 6 units of insulin for the blood glucose level of 401 to 450 mg/dL, - to inject 7 units of insulin for the blood glucose level of 451 to 500 mg/dL, - if the blood glucose level was above 400 mg/dL, to call the physician and Resident 1 would need an endocrine consult. Review of Resident 1's plan of care failed to show a care plan problem was developed for Resident 1's use of insulin lispro medication. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/2/26 at 1106 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 reviewed Resident 1's medical records and verified the above findings. On 2/5/26 at 1423 hours, an interview was conducted with the CNO and RN Manager. The CNO and RN Manager were informed and acknowledged the above findings. 3. On 1/29/26 at 1032 hours, an observation was conducted in Resident 5's room. Resident 5 was observed with Pedia Sure Peptide 1.5 (enteral feeding formula) infusing at 23 ml/hr. The label on the formula showed it was hung on 1/29/26 at 0600 hours. Medical record review for Resident 5 was initiated on 2/2/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 2/2/26, showed the resident did not have the capacity to understand and make decisions. Reviewed of Resident 5's Physician's Orders showed the following physician's orders: - dated 1/8/26, for J-tube feeding with Pedia Sure Peptide 1.5 at 23 ml/hr for 20 hours; - dated 1/9/26, may use J-tube for all meds and flushes until further evaluation ordered; and - dated 1/28/26, water flush 60 ml GT and 50 ml every four hours. Review of Resident 5's plan of care failed to show a care plan problem was developed for Resident 5's use of the GJ tube. On 2/2/26 at 0808 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 2. RN 2 reviewed Resident 5's medical record and verified the facility failed to develop a care plan specific to the use GJ tube feeding for Resident 5. On 2/5/26 at 1355 hours, an interview with the CNO was conducted. The CNO was informed and acknowledged the above finding. 4. According to DailyMed- National Library of Medicine, the black box warning for the duloxetine and trazodone medications showed a warning for suicidal thoughts and behaviors- antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and the emergence of suicidal thoughts and behaviors. Review of the facility' P&P titled Psychotropic Drugs dated 7/2025, showed the resident's plan of care shall include the specific behavior(s) for which the medication is being used, the goal of therapy, and common side effects of the medication. Medical record review for Resident 6 was initiated on 1/29/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 12/12/25, showed Resident 6 had diagnoses including depression and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's Physician's Orders, showed the following physician's orders: - dated 12/21/25, to administer duloxetine delayed-release 30 mg daily via GT for depression; and - dated 1/7/26, to administer trazodone 200 mg via GT at bedtime. Review of Resident 6's plan of care failed to show a care plan problem was developed for Resident 6's use of the duloxetine and trazodone antidepressant medications. On 2/5/26 at 0942 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 3. RN 3 reviewed Resident 6's medical records and verified a care plan was not developed for Resident 6's use of the trazodone and duloxetine antidepressant medications. On 2/5/26 at 1148 hours, an interview was conducted with the Nurse Manager. The Nurse manager stated for the residents who were administered the antidepressant medications, there should be a care plan developed and implemented specific to the antidepressant medications and the monitoring of the medications' side effects. 5. On 1/29/26 at 0910 hours, during the initial tour of the facility, Resident 9 was observed lying in bed. Resident 9 was observed with Jevity 1.2 (enteral feeding formula) infusing at 52 ml/hr via the GT. Medical record review for Resident 9 was initiated on 1/29/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 12/7/25, showed Resident 9 was GT feed dependent. Review of Resident 9's Physician's Orders showed a physician's order dated 1/6/26, to administer Jevity 1.2 at 52 ml/hr via the GT. Review of Resident 9's plan of care failed to show a care plan problem was developed to address Resident 9's use and management of the GT. On 2/2/26 at 0946 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 2. RN 2 verified the above findings. RN 2 stated there should be a care plan developed specific to the use of the enteral feeding via the GT to ensure the residents plan of care was addressed and the goals met. On 2/5/26 at 1147 hours, an interview was conducted with the Nurse Manager. The Nurse Manager stated for the residents receiving the enteral feedings via the GT, a care plan should be developed for the GT management including the interventions to meet the goals and prevent complications. On 2/5/26 at 1417 hours, an interview was conducted with the Nurse Manager and CNO. The Nurse Manager and CNO were informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, 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 food was properly labeled in the refrigerator. * The facility failed to ensure items in the kitchen were discarded after the use-by/expiration date. * The facility failed to ensure the kitchen equipment was stored or kept in sanitary conditions. * The facility failed to ensure the kitchen equipment was air-dried. * The facility failed to ensure the microwave was kept in clean and sanitary condition. * The facility failed to ensure the food preparation sinks had an air gap. These failures had the potential for exposure to food-borne illnesses for a medically vulnerable population.Findings: On 1/29/26 at 0840 hours, an interview was conducted with the DSS. The DSS stated there were two of 15 residents who consumed food from the kitchen. 1. Review of the facility's P&P titled Food and Supply Storage revised 1/2025 showed all food, non-food items, and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. To cover, label, and date unused portions and open packaged. Use the Medvantage/Fresh date labeling system or complete all sections on a [NAME] orange label. Products are good through the close of business on the date noted on the label. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, a container was observed with an orange-colored liquid inside of Refrigerator 1. The container did not have a label to identify what the liquid was or the date the container of liquid entered the refrigerator. The DSS verified the above findings and stated when the items entered the refrigerator, it should be labeled with the content of the item, the date, and the use-by date. 2. Review of the facility's P&P titled Food and Supply Storage revised 1/2025 showed most but not all products contain an expiration date. The words sell-by, best-by, enjoy-by, or use-by should precede the date. Foods past the use-by, sell-by, best-by, or enjoy-by date should be discarded. To date and rotate items; first in, first out. Discard food past the use-by or expiration date. a. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, the following was observed:- 16 bottles of Glucerna with the use by date of 1/1/26 in Refrigerator 1,- Two 1/2-gallon cartons of Silk Vanilla Soy Milk with the expiration date of 1/15/26 in Refrigerator 1; and- one metal pan containing two bags of thawed chicken in Refrigerator 2. The label showed good through 1/27/26. The DSS verified the above findings and stated the items should have been discarded. The DSS further stated the refrigerators were checked by the diet clerks daily and the diet clerks were responsible for removing the expired items from the refrigerator. b. On 1/29/26 at 0858 hours, during the initial tour of the kitchen with the CDM, the following were observed in the dry storage room:- one container of Vanilla Creme Icing with the expiration date of 6/25/25; and- one box of chocolate brownie mix with the expiration date of 12/18/25. The CDM verified the above findings. 3. According to the USFDA Food Code 2022 (undated), 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Review of the facility's P&P titled Cleaning of Food and Nonfood Contact Surfaces revised 1/2025 showed the food-contact surface of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, the following was observed:- one metal spatula was observed with dry food particles;- one yellow lemon squeezer was observed with brownish dry residue; and- one peeler was observed with dry, crusted residue on the blade. The DSS verified the above findings and stated the kitchen utensils should be clean. 4. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the USFDA Food Code 2022 (undated), 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 Storage of Pots, Dishes, Flatware, Utensils revised 1/2023 showed to air dry all food contact surfaces, including pots, dishes, flatware, and utensils before storage, or store in a self-draining position. Do not stack or store when wet. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, a blender was observed on the blender base, ready for use. The blender was wet with water residue on the inner walls and the blender blade. The blender lid was also observed wet. The DSS verified the above findings and stated the kitchen equipment should be completely air-dry prior to use. 5. According to USFDA 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. Review of the facility's P&P titled Cleaning of Food and Nonfood Contact Surfaces revised 1/2025, showed nonfood contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and their debris. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, the microwave was observed with dry food particles and residue on the top inner compartment. The DSS verified the above findings and stated the microwave was used to heat up soups for the patients. The DSS stated the microwave should be cleaned after every use. 6. According to USFDA Food Code 2022 (undated), 5-202.13 - Backflow prevention, Air Gap, showed an air gap between the water supply inlet and the food level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (one inch). According to USFDA Food Code 2022 (undated), 5-202.14 - Backflow Prevention Device, Design Standard, a backflow or backsiphonage prevention device installed on a water supply system shall meet American Society of Sanitary Engineering standards for construction, installation, maintenance, inspection, and testing for that specific application and type of device. On 1/29/26 at 0840 hours, during the initial tour of the kitchen with the DSS and the House Supervisor, the food preparation sinks to the left and the right of Refrigerator 2 were not observed with an air gap. The DSS verified the sinks were used for food preparation. On 2/5/26 at 0830 hours, an interview was conducted with the Maintenance Mechanic. The Maintenance Mechanic stated the purpose of an air gap was to prevent the backflow of water back into the sink compartment. The Maintenance Mechanic verified the food preparation sinks to the left and the right of Refrigerator 2 did not have an air gap and the drains were connected and led to the mainline. On 2/5/26 at 1443 hours, an interview and concurrent observation of the food preparation sinks was conducted with the Maintenance Mechanic, CDM, and Regional Consultant. The Maintenance Mechanic stated the drains from the food preparation sinks had a contraption called the P-trap, and the purpose of the contraption was to prevent the backflow of water. Inspection of the drain contraption showed a U-shaped design, with all the drains connected. The mechanism to show how the contraption prevented the backflow of water was unable to be visualized and the facility was unable to provide any documentation on the specific design of the contraption and how or where it prevented the backflow of contaminated water. On 2/5/26 at 1445 hours, an interview was conducted with the Nurse Manager. The Nurse Manager was informed and acknowledged the above findings.

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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 maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for January 2025. The facility conducted surveillance only on the residents who exhibited signs and symptoms of an infection and were prescribed antimicrobial medications. The facility failed to ensure the residents exhibited signs and symptoms of an infection but were not prescribed antimicrobial medications were included in the facility's infection control surveillance log, and in the monthly infection surveillance report. * LVN 2 failed to perform hand hygiene prior to donning gloves when administering medications. These failures posed the risk for not identifying resident infections and thereby, preventing the implementation of interventions to control the potential transmission of communicable diseases to other residents in the facility, and had the potential to spread infection in the facility.Findings: 1. Review of the facility's P&P titled Pediatric Sub-Acute Infection Prevention and Control Program Plan revised 2/2025 showed an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Peds Sub-Acute Infection Prevention Program Plan uses sound epidemiologic principles to implement, evaluate, and improve infection prevention and control strategies. Surveillance, epidemiological investigation, consultation, and education are critical components of the program. Prevention and control efforts will include, but are not limited to: - Identifying, managing, and reporting persons with transmissible diseases as mandated by the state communicable disease regulations. - Identifying infections in patients present on admission or occurring thereafter and infections present in staff upon initial employment or arising from an exposure event. - Measuring, monitoring, evaluating, and reporting program effectiveness. - Expanding activities as needed in response to unusual events or to control disease outbreaks promptly. On 2/5/26 at 1136 hours, a concurrent interview, medical record review, and facility document review was conducted with the IP. The IP was asked to show the facility's infection control surveillance program for January to December 2025. Review of the Infection Prevention and Control Surveillance Log for January 2025 showed the infection control surveillance was only conducted for residents prescribed with antimicrobials. There was no documented evidence of surveillance for the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications, such as the residents who were tested for COVID-19 were included in the surveillance log. Review of the facility's document showed there were three residents diagnosed with Influenza and were prescribed Antiviral medication. However, these three residents were tested with COVID-19 but not included in the surveillance log. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	When the IP was asked to describe the facility's infection surveillance program, the IP stated she would initially do an order listing of the report. The IP stated she would then manually enter the information of the residents prescribed with antibiotics to the surveillance log. The IP stated she conducted surveillance only on the residents with infections who were prescribed antimicrobial medications. When asked if the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications were included in the surveillance, the IP stated she did not include the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications such as those residents with Influenza. On 2/5/26 at 1431 hours, an interview was conducted with the CNO. The CNO was informed and verified the above findings. 2. Review of the facility's P&P titled Hand Hygiene revised 7/2025 showed hand hygiene is the single most important strategy to prevent the spread of infection. The indications for handwashing with alcohol based hand rub included before and after direct contact with patients, before handling patient medication, and before donning gloves. a. On 1/29/26 at 0938 hours, a medication administration observation for Resident 4 was conducted with LVN 2. Resident 4 was on EBP. LVN 2 was observed preparing the following medications:- one packet of polyethylene glycol (laxative medication) 17 gm;- one tablet of multivitamin (supplement);- one tablet of phenobarbital (anti-convulsant medication) 60 mg;- one tablet of lactobacillus acidophilus (probiotic) 0.2 mg;- one tablet of trihexyphenidyl hydrocholoride (anticholinergic medication) 2 mg;- one tablet of baclofen (muscle relaxant medication) 10 mg;- one tablet of baclofen 20 mg;- 2.125 ml of oral solution of sodium chloride (electrolyte) 23.4%; and- 0.6 ml of simethicone (antiflatulent medication) oral drops 40 mg / 0.6 ml. LVN 2 was observed donning gloves and a gown when she entered Resident 4's room to administer the medications. LVN 2 did not perform hand hygiene prior to donning PPE. LVN 2 then administered Resident 4's GT medications. b. On 1/29/26 at 1004 hours, a medication administration observation for Resident 17 was conducted with LVN 2. Resident 17 was on EBP. LVN 2 was observed preparing the following medications:- one packet of polyethylene glycol 17 gm;- 3 ml of glycopyrrolate (anticholinergic medication) 0.2 mg / ml;- 10 ml of docusate sodium (laxative medication) 100 mg / 10 ml;- one packet of esomeprazole (proton pump inhibitor) delayed release oral suspension 10 mg;- half tablet of propranolol hydrocholoride (blood pressure medication) 10 mg;- two capsules of gabapentin (anti-convulsant medication) 100 mg;- half tablet of tizanidine (muscle relaxant medication) 2 mg;- 1.5 ml of cholecalciferol (supplement) solution 400 units / ml; and- 0.6 ml of simethicone oral drops 40mg / 0.6 ml. LVN 2 was observed donning gloves and a gown when she entered Resident 17's room to administer the medications. LVN 2 did not perform hand hygiene prior to donning PPE. LVN 2 then administered Resident 17's GT medications. On 1/29/26 at 1046 hours, an interview was conducted with LVN 2. LVN 2 stated the purpose of hand hygiene was to ensure the safety of the patient and nurses and to promote infection control. LVN 2 verified she did not perform hand hygiene prior to donning gloves during the medication administration observation for Residents 4 and 17. On 2/5/26 at 1423 hours, an interview was conducted with the CNO and RN Manager. The CNO and RN Manager were informed and acknowledged the above findings.

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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, and facility P&P review, the facility failed to ensure staff provided care and promoted dignity and respect for two of nine final sampled residents (Residents 10 and 18). * The facility failed to ensure the privacy curtain was drawn for Resident 10 when CNA 1 was changing and providing care to the resident. * The facility failed to ensure the privacy curtain was drawn for Resident 18 when RT 1 was suctioning the resident. These failures had the potential to negatively impact the residents' feelings of self-worth and well-being.Findings: Review of the facility's P&P titled Resident Rights dated 7/2025 showed the residents have the right to be treated with consideration, respect, and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs. 1. Review of the facility's P&P titled Bath-In Bed dated 9/2025 showed all pediatric residents will be bathed daily following the assigned schedule. To identify the resident, explain the procedure to the resident and bring the equipment to the bedside, and to provide the resident with privacy. Medical record review for Resident 10 was initiated on 1/29/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 2/2/23, showed Resident 10 had hypoxic ischemic encephalopathy with persistent vegetative state. On 1/29/26 at 0920 hours, an observation and concurrent interview was conducted with LVN 1. Resident 10 was lying in bed and CNA 1 was providing care to the resident. Resident 10's abdomen was exposed. The privacy curtain was on the left side of Resident 10's bed and not drawn to provide privacy between Resident 10 and his roommate. LVN 1 verified the above finding. LVN 1 stated when the care was provided to the residents, the privacy curtain should be drawn to provide the residents with privacy and dignity. On 1/29/26 at 0927 hours, an interview was conducted with CNA 1. CNA 1 stated she was giving Resident 10 a partial bed bath and changing his clothes. CNA 1 verified she did not pull the curtain to provide Resident 10 with privacy, and stated she should have pulled the curtain. On 2/5/26 at 1147 hours, an interview was conducted with the Nurse Manager. The Nurse Manager stated the staff should ensure the residents were covered and the curtains should be pulled to provide the residents with privacy and dignity when changing the resident or providing care in the bed. On 2/5/26 at 1417 hours, an interview was conducted with the Nurse Manager and CNO. The Nurse Manager and CNO were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Suctioning Airway Pediatric dated 9/2025 showed suctioning the airway of the resident was performed by an RN or RT. The procedures in performing suctioning the residents include the provision of privacy. Medical record review for Resident 18 was initiated on 1/29/26. Resident 18 was admitted to the facility on [DATE]. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/2/26 at 1047 hours, during an interview with CNA 2 inside Resident 18's bedroom, RT 1 entered the room and stated he would suction Resident 18. RT 1 donned PPE and proceeded to suction Resident 18. The privacy curtain was not drawn and other staff in the hallway were able to see and talk to RT 1. On 2/2/26 at 1055 hours, an interview was conducted with RT 1. RT 1 stated he prepared everything needed before suctioning the resident. RT 1 was informed of the observation and verified there was another staff asking him a question from the hallway while he was suctioning Resident 18. RT 1 verified the findings. On 2/5/26 at 1013 hours, an interview was conducted with the CNO. The CNO was informed and verified the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to fully inform the resident or responsible party and obtain a completed informed consent prior to the use of the psychotropic medications for one of five final sampled residents (Resident 15) reviewed for unnecessary psychotropic medications. *The facility failed to ensure the informed consent was obtained from Resident 15's representative prior to the use of lorazepam (antianxiety medication) and diazepam (antianxiety medication). This failure had the potential for Resident 15 and their responsible party to be unaware of the risks associated with psychotropic medications and the potential side effects.Findings: Review of the facility's P&P titled Psychotropic Drugs revised 7/2025 showed a signed consent is required for administration of psychotropic drugs. Medical record review for Resident 15 was initiated on 2/5/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Physician's Orders, showed the following physician's orders:- dated 9/1/25, to administer diazepam 2 mg, one tablet via GT every six hours for muscle spasms and neurological irritability; and- dated 12/17/25, to administer lorazepam 1 mg, one tablet via GT every six hours as needed for increased toning and neuro-irritability (state of persistent, often unexplainable, crying, agitation) as evidenced by heart rate greater than 140 bpm. Review of Resident 15's MAR for January and February 2026 showed the following:- Resident 15 was administered the diazepam medication from 1/1 to 2/4/26.- Resident 15 was administered the lorazepam medication on 1/20/26 at 0827 hours. Review of Resident 15's H&P examination dated 2/4/26, showed Resident 15 was neurologically devastated (describes a condition where a patient has suffered severe, often irreversible damage to the brain). Review of Resident 15's medical record failed to show an informed consent was obtained from Resident 15's representative prior to the resident receiving the diazepam and lorazepam medications. On 2/5/26 at 1037 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 3. RN 3 stated the facility obtained consent for psychotropic medications, however, Resident 15 did not have a consent form for diazepam and lorazepam because the medications were used for Resident 15's increased toning (the continuous and passive partial contraction of muscles, or the resting tension in a muscle that helps maintain posture and stability) and neuro-irritability. RN 3 verified the above findings. On 2/5/26 at 1417 hours, an interview was conducted with the CNO and RN Manager. The RN Manager stated the licensed nursing staff would obtain consent for psychotropic medications. Furthermore, the RN Manager stated Resident 15 did not have a consent form for diazepam and lorazepam because the facility did not use the medications for psychoactive indications. The CNO and RN Manager were informed and acknowledged the above findings.

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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 two of five sampled residents (Residents 6 and 15) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure the physician's order for the duloxetine (antidepressant medication) and trazodone (antidepressant medication) had the specific behavior manifestations for Resident 6. Additionally, the facility failed to ensure Resident 6 was monitored for the specific behaviors and side effects/adverse reactions related to the use of the duloxetine and trazodone medications. * The facility failed to ensure Resident 15 was monitored for the specific behaviors and side effects/adverse reactions related to the use of the lorazepam (antianxiety medication) and diazepam (antianxiety medication). Additionally, the facility failed to ensure the physician documented the rationale for extending the PRN lorazepam medication for Resident 15. These failures had the potential for the residents to experience potential harm from the adverse consequences from the use of psychotropic medications and the potential for not providing the physician with the accurate data of the residents' behavior occurrences each month, in an effort to discontinue the use of psychotropic medications.Findings: Review of the facility's P&P titled Psychotropic Drugs dated 7/2025 showed all residents receiving routine and as needed medication(s) prescribed for control of a specific behavior or manifestation of a disordered thought process shall be monitored for effectiveness and side effects. Therapeutic and toxic data will be reported to the physician. A physician's order is required with the following information included: Purpose of treatment, Drug, frequency, route, duration, Probable duration: a. temporary, b. long term Possible side effects or significant risks commonly known by health professionals, Reasonable alternative treatment Further review of the P&P showed the staff shall monitor and record the occurrence of aberrant behavior on the behavior sheet, nurse's notes effects on the behavior summary sheet. The staff shall observe and document the occurrence of medication side effects in the nurse's notes. Monthly, the staff shall summarize the incidence of behavior episodes and side effects on the behavior summary sheet. 1. According to DailyMed- National Library of Medicine (undated), the black box warning for the duloxetine and trazodone antidepressant medications showed a warning for suicidal thoughts and behaviors. Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents, and young adults in short-term studies. In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and the emergence of suicidal thoughts and behaviors. Medical record review for Resident 6 was initiated on 1/29/26. Resident 6 was admitted to the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE]. Review of Resident 6's H&P examination dated 12/12/25, showed Resident 6 had diagnoses including depression and anxiety. Review of Resident 6's Physician's Orders showed the following physician's orders: - dated 12/21/25, to administer duloxetine delayed release 30 mg daily via GT for depression; and - dated 1/7/26, to administer trazodone 200 mg via GT at bedtime. Further review of the physician's orders failed to show the purpose of treatment for the psychotropic medications, the specific manifesting behaviors, and the side effects related to the use of the antidepressant medications. Review of Resident 6's Physician's Consultation Note dated 12/20/25, showed Resident 6 reported having increased depression and denied any suicidal thoughts. Review of Resident 6's medical record failed to show documented evidence Resident 6 was monitored for the specific behaviors and side effects related to the use of the duloxetine and trazodone medications. On 2/5/26 at 0942 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 3. RN 3 stated the physician's orders for the administration of the psychotropic medications should include the diagnosis and the specific behaviors related to the use of the psychotropic medication. RN 3 stated for the residents administered the psychotropic medications, the specific manifesting behaviors should be monitored every shift to track and determine if the medication was effective. RN 3 reviewed Resident 6's medical records and verified the above findings. RN 3 verified there were no documentation of the monitoring Resident 6 for the specific behaviors and side effects related to the use of the duloxetine and trazodone psychotropic medications. On 2/5/26 at 1148 hours, an interview was conducted with the Nurse Manager. The Nurse Manager stated the physician's order for the administration of the psychotropic medications should include the medication name, dose, route, frequency, and the indication of use and the specific manifesting behavior. The Nurse Manger stated the resident should be monitored for the effectiveness of the psychotropic medication by monitoring for the occurrence of the specific behavior. The Nurse Manager further stated the licensed nurses were expected to monitor the resident for the specific behaviors and the side effects related to the use of the psychotropic medications and document in the nurse's progress notes. On 2/5/26 at 1417 hours, an interview was conducted with the Nurse Manager and CNO. The Nurse Manager and CNO were informed and acknowledged the above findings. 2. Medical record review for Resident 15 was initiated on 2/5/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's H&P examination dated 2/4/26, showed Resident 15 had the diagnosis of spasticity (a neurological motor disorder characterized by increase in muscle tone, stiffness, and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exaggerated reflexes). Review of Resident 15's Physician's Orders, showed the following physician's orders: - dated 9/1/25, to administer diazepam 2 mg, one tablet via GT every six hours for muscle spasms and neurological irritability; and - dated 12/17/25, to administer lorazepam 1 mg, one tablet via GT every six hours as needed for increased toning and neuro-irritability (state of persistent, often unexplainable, crying, agitation) as evidenced by heart rate greater than 140 bpm. In addition, the PRN lorazepam medication had a stop date of 12/17/26. There was no documented evidence of the rationale to extend the PRN lorazepam medication and the side effects related to the use of the psychotropic medications in the physician's orders. Review of Resident 15's MAR for January and February 2026 showed the following: - Resident 15 was administered the diazepam medication from 1/1 to 2/4/26. - Resident 15 was administered the lorazepam medication on 1/20/26 at 0827 hours. Further review of Resident 15's medical record failed to show documented evidence Resident 1 was monitored for the specific behaviors and side effects related to the use of the diazepam and lorazepam medications. On 2/5/26 at 1037 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 3. RN 3 stated if a medication was routinely administered to the resident, the licensed nurses did not need to document the resident's behavior. RN 3 stated there was no documentation of the monitoring for Resident 15's specific behaviors and side effects related to the use of the diazepam and lorazepam medications RN 3 verified the above findings. On 2/5/26 at 1417 hours, an interview was conducted with the CNO and RN Manager. The CNO and RN Manager were informed and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 appropriate care and services for the use of GT for one of nine final sampled residents (Resident 9) reviewed for tube feedings. * The facility failed to ensure Resident 9's HOB was elevated 30 degrees or greater during the enteral feeding to reduce the risk of aspiration. These failures posed the risk for complications related to use of the GT for Resident 9.Findings: Review of the facility's P&P titled Gastrostomy Tube Feedings dated 7/2025 showed under the section Mechanical Pump Feedings, to explain the procedure to the resident and elevate the HOB to high or semi-Fowler's, if possible. On 1/29/26 at 0910 hours, during the initial tour of the facility, Resident 9 was observed lying in bed with Jevity 1.2 (enteral feeding formula) infusing at 52 ml/hr via the GT. The indicator on Resident 9's side rail showed the HOB was less than 30 degrees. Medical record review for Resident 9 was initiated on 1/29/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 12/7/25, showed Resident 9 was GT feed dependent. Review of Resident 9's Physician's Orders showed an order dated 1/6/26, to administer Jevity 1.2 at 52 ml/hr via the GT. On 1/29/26 at 0917 hours, an observation of Resident 9 and concurrent interview was conducted with LVN 1. LVN 1 stated when the enteral feeding was infusing, the HOB should be elevated at 30 degrees or more to prevent aspiration. LVN 1 verified the above findings. LVN 1 further stated Resident 9 becomes agitated when the HOB was greater than 30 degrees. On 2/2/26 at 0811 hours, during an observation, Resident 9 was lying in bed with the enteral feeding formula infusing at 52 ml/hr. The HOB indicator on Resident 9's side rail showed the HOB was less than 30 degrees. On 2/2/26 at 0946 hours, an interview and concurrent medical record review for Resident 9 was conducted with RN 2. RN 2 stated the indicator on the resident's side rail showed the angle of the HOB. RN 2 stated when the enteral feeding formula was infusing, the resident's HOB should be 30 degrees or more to prevent aspiration. RN 2 reviewed Resident 9's medical record and verified Resident 9 did not have a physician's order for Resident 9's HOB to be less than 30 degrees during the enteral feedings. Review of Resident 9's Physician's Orders showed an order dated 2/2/26, may have the head flat per the family's request. On 2/5/26 at 1147 hours, an interview and concurrent medical record review for Resident 9 was conducted with the Nurse Manager. The Nurse Manager stated for residents with the enteral feedings, the HOB should be at least 30 degrees or more to prevent complications like aspiration when the enteral feeding was infusing. The Nurse Manager stated for the residents whose family requested for the resident's HOB to be less than 30 degrees when the enteral feeding was infusing, there should be a physician's order for it to be okay to lay the resident flat. The Nurse Manager further stated if there was a physician's order to lay the resident flat or less than 30 degrees when the enteral feedings were infusing, then there should be nursing documentation in the resident's medical record to show the licensed nurses assessed the resident for aspiration and documented the presenting symptoms and interventions the licensed nurse attempted prior to lowering the resident's head of bed below 30 degrees while the enteral feeding was infusing. When asked about a physician's order for Resident 9 HOB, the Nurse Manager verified Resident 9's physician's order showed the resident could have the head flat per the family's request. The Nurse Manager verified the order was not specific to include during the enteral feedings. On 2/5/26 at 1417 hours, an interview was conducted with the Nurse Manager and CNO. The Nurse Manager and CNO were informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure one of five sampled residents (Resident 6) reviewed for unnecessary medications was free from the unnecessary medications. * The facility failed to ensure Resident 6 was monitored for signs and symptoms of bleeding related to the use of the enoxaparin (anticoagulant) therapy. This failure had the potential for Resident 6 to receive unnecessary medications and develop significant adverse effects.Findings: According to DailyMed- National Library of Medicine (undated) showed the following adverse reactions listed for the enoxaparin medication: spinal/epidural hematoma, increased risk of hemorrhage, and thrombocytopenia. Medical record review for Resident 6 was initiated on 1/29/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's H&P examination dated 12/12/25, showed Resident 6 had diagnoses including quadriplegia. Review of Resident 6's Physician's Orders showed a physician's order dated 12/11/25, to administer enoxaparin 30 mg subcutaneous every 12 hours for anticoagulation, prophylaxis of VTE/PE; high alert medication; black box warning. The physician's orders for the enoxaparin medication did not include the monitoring for side effects. Review of Resident 6's care plan for risk for bleeding dated 2/2/26, showed interventions including to assess Resident 6 for signs and symptoms of bleeding. Review of Resident 6's medical record failed to show documented evidence Resident 6 was monitored for signs and symptoms of bleeding. On 2/2/26 at 1011 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 2. RN 2 stated for the residents who were on the anticoagulation therapy, the residents should be monitored for signs and symptoms of bleeding and bruising by the licensed nurses every shift. RN 2 reviewed Resident 6's medical record and verified the above findings. RN 2 stated there was no documentation that Resident 6 was assessed or monitored for signs and symptoms of bleeding. On 2/5/26 at 1148 hours, an interview was conducted with the Nurse Manager. The Nurse Manager stated for the use of anticoagulation therapy, the residents should be monitored for bleeding. The Nurse Manager further stated the licensed nurses were expected to assess for signs and symptoms of bleeding and document the assessments in the nursing progress notes. On 2/5/26 at 1417 hours, an interview was conducted with the Nurse Manager and CNO. The Nurse Manager and CNO were informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility document review, medical record review and facility P&P review, the facility failed to ensure the antibiotic stewardship program monitored and addressed the use of the antibiotics for one of nine final sampled residents (Resident 10) and one nonsampled resident (Resident 16) . * The facility failed to monitor and address the use of antibiotics when the resident's condition did not meet McGeer's criteria. This failure had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled Antibiotic Stewardship Program dated 9/2022 showed the facility should optimize clinical outcomes while minimizing unintended consequences of antimicrobial appropriate use of antibiotic included criteria met for clinical definition of active infection or suspected sepsis and pathogen susceptibility, based on culture and sensitivity, to antimicrobial (or therapy begun while culture is pending). The members of the Antibiotic Stewardship Program included to discuss antimicrobial order changes with the physician or prescriber and monitor antimicrobial therapy to evaluate the appropriateness of use. Review of the facility's P&P titled McGeer Criteria undated showed healthcare personnel will utilize the McGeer Criteria to identify and classify infections occurring among patients. Effective communication of infection classification and corresponding control measures will occur among healthcare teams to ensure a coordinated approach to patient care. Data on infections classified according to the McGeer Criteria will be collected regularly to monitor trends, evaluate the effectiveness of infection control interventions, and facilitate quality improvement initiatives. Based on the classification of infections using the McGeer Criteria, appropriate infection prevention and control measures will be implemented. The classification of infections according to the McGeer Criteria and corresponding infection prevention measures will be documented accurately and maintained in accordance with organizational policies and regulatory requirements. Review of the facility's Infection Control Surveillance Log dated February 2025 showed Resident 16 was prescribed an antibiotic for a respiratory tract infection but did not meet McGeer's Criteria. Review of the facility's Infection Control Surveillance Log dated August 2025 showed Resident 10 was prescribed an antibiotic for a respiratory tract infection but did not meet McGeer's Criteria. Medical record review for Residents 10 and 16 were initiated on 2/5/26. Resident 10 was admitted to the facility on [DATE] and Resident 16 was admitted to the facility on [DATE]. Review of Residents 10 and 16's medical records failed to show documented evidence the physician was notified of the infections that did not meet McGeer's Criteria. On 2/5/26 at 1216 hours, an interview, medical record review and concurrent facility document review was conducted with the IP. The IP verified the above findings. The IP stated the facility used McGeer's Criteria as the facility's antibiotic stewardship program. The IP could not show documentation if the physicians were notified on when the infection criteria was not met for the above residents. On 2/5/26 at 1431 hours, an interview was conducted with the CNO. The CNO was informed and verified the above findings.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and facility document review, the facility failed to ensure the Facility Assessment was complete. * The facility failed to ensure the Facility Assessment addressed or included the following: active involvement of required individuals in developing facility assessment, resources necessary to care for residents including weekends, include a plan to maximize recruitment and retention of direct care staff and include a contingency plan for staffing needs. This failure had the potential not to meet the residents' care needs if the assessed population's needs and resources were not comprehensively identified and addressed.Findings: According to the CMS QSO-24-13-NH dated 6/18/24, with an implementation date of 8/8/24, CMS had issued a revised guidance for long-term care facility assessment requirement. The Facility Assessment should address and included the active involvement of the direct care staff in developing the Facility Assessment. Also included the staffing resources necessary to care for the residents, including the weekends; a plan to maximize recruitment and retention of direct care staff member, and a contingency plan for staffing needs for the events not to activate the facility's emergency plan. Review of the Facility's Assessment for 2025 did not show the direct care staff members, direct care representatives, residents, residents' representatives, and residents' family members were actively involved in developing the Facility Assessment. Additionally the Facility Assessment did not show resources necessary to care for residents including weekends, a plan to maximize recruitment and retention of the direct care staff and a contingency plan for staffing needs. On 2/2/26 at 1124 hours, an interview and concurrent facility document review of the Facility Assessment was conducted with the CNO. The CNO reviewed the Facility Assessment for 2025 and verified the above findings. The CNO further verified there were no resources necessary to care for residents including weekends, and no documentation of a plan to maximize recruitment and retention of direct care staff and a contingency plan for staffing needs in the Facility Assessment. The CNO verified the Facility Assessment for 2025 was not updated based on the latest guidance from the CMS.

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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 0842 Level of Harm - Potential for minimal 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, medical record review, and facility P&P review, the facility failed to ensure the POLST for one of nine final sampled residents (Resident 1) was completed. * Resident 1's POLST was incomplete. This failure had the potential for Resident 1's care needs to not be met as their medical information was not complete.Findings: Review of the facility's P&P titled Life Sustaining Treatment Physician Orders (POLST) revised 7/2025 showed the POLST is a document that describes the patient's specific wishes for end of life treatment. The POLST clarifies the patient's treatment intentions, minimizes confusion about patient preferences, and complements the patient's advance health directive. Medical record review for Resident 1 was initiated on 1/29/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's POLST dated 12/1/22, showed Section D for the advance directive was not completed. On 2/2/26 at 1106 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 2. RN 2 verified the above findings. On 2/5/26 at 1423 hours, an interview was conducted with the CNO and RN Manager. The CNO and RN Manager were informed and acknowledged the above findings.