STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555737	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire San Dimas Post-Acute	1740 S San Dimas Ave San Dimas, CA 91773

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 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. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 4) was treated with dignity and respect when Licensed Vocational Nurse (LVN) 1 made Resident 4 use a bedpan (a shallow, portable receptacle shaped like a toilet bowl, used as a toilet by people who are too ill, injured, or immobile to get out of bed to use a regular toilet for urination or defecation) instead of assisting Resident 4 to the toilet in the bathroom.This failure made Resident 4 verbalized Do they (staff) wanted me (Resident 1) to die and had the potential to result in Resident 4 feeling disrespected and had the potential for Resident 4 experience a decline in psychosocial well-being.Findings:During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted Resident 4 on [DATE] with diagnoses including abnormalities of gait (manner of walking or moving on foot) and mobility (ability to move), muscle wasting and atrophy (the loss or thinning of muscle tissue, leading to decreased mass and strength), and need for assistance with personal care.During a review of Resident 4's History and Physical Examination (H&P), dated [DATE], the H&P indicated, Resident 4 could make needs known but could not make medical decisions.During an interview on [DATE], at 2:21 PM with Resident 4's Caregiver (CG 1), CG 1 stated that on [DATE] at 1 AM, CG 1 asked the facility staff to assist Resident 4 to use the bathroom. CG 1 stated LVN 1 instructed the unidentified Certified Nursing Assistant (CNA) to assist Resident 4 in using a bedpan. CG 1 stated CG 1 told LVN 1 Resident 1 had been getting out of bed and using the toilet in the bathroom. CG 1 stated LVN 1 claimed the night shift was low staffed so Resident 4 would have to use a bedpan instead of going to the bathroom to use the toilet. GC 1 stated the facility staff (unidentified) placed Resident 4 on a bedpan and refused to let Resident 4 use the toilet in the bathroom. CG 1 stated Resident 4 did not want to use the bedpan. CG 1 stated Resident 4 stated, What are you doing, why are you hurting me?During a concurrent interview and record review on [DATE] at 1:31 PM with the Director of Rehab (DOR), Resident 4's Care Plan Report (CPR), undated was reviewed. The CPR indicated on [DATE], a care plan was initiated to address Resident 4's mobility and safety. The care plan indicated CNAs (in general) should use 2 staff persons when transferring Resident 4. The DOR stated the physical Therapist (PT) (in general) assessed Resident 4 and indicated in the care plan how to safely transfer Resident 4 in and out of bed. The DOR stated the instructions from PT to nursing was for nursing staff (in general) to use a 2 person assist when transferring Resident 4 in and out of the bed. The DOR stated Resident 4 was safe to get out of bed if there were two people assisting Resident 4.During a telephone interview on [DATE] at 3:01 PM with LVN 1, LVN 1 stated LVN 1 instructed the CNA's (unidentified) to put Resident 4 on a bedpan during the night shift, on [DATE]. LVN 4 confirmed that CG 1 requested for Resident 4 to get out of bed and use the toilet. LVN 1 stated LVN 1 chose to make Resident 4 use a bedpan instead because Resident 4 required 2 staff persons to assist Resident 4 for transfers from the bed. During a concurrent interview and record review on [DATE] at 10:16 AM with the Director of Staff Development (DSD), Resident 4's Kardex Report (KR), undated, was reviewed. The KR indicated Resident 4 was 2 persons assist for transfers. The DSD stated LVN 1 should have allowed Resident 4 to get out of bed to use the toilet. The DSD stated the facility was not short staffed at nighttime or any shift. The DSD stated it was Resident 4's right to get out of bed to use the toilet. The DSD stated allowing the residents (in general) to use the toilet also protected the residents (in general) dignity.During a review of the facility's policy and procedure (P&P) titled, Quality of Life - Dignity, revised February 2020, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated, . Demeaning -practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example. promptly responding to a resident's request for toileting assistance.

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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. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 1), was notified when Resident 1's medication was changed from tramadol (a medication used to treat pain) to norco (a medication used to treat pain) on 9/11/2025.This failure resulted in the violation of Resident 1's right to be informed of Resident 1's treatment for pain and had the potential in Resident 1 to experience unrelieved pain. (Cross Reference F580, F755, F806, and 5842)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses including fracture (broken bone) of unspecified part of neck of right femur (thigh bone), dislocation of right hip (a medical emergency where the thigh bone pops out of the hip socket), and need for assistance with personal care. The AR indicated Resident 1 was discharged to General Acute Care Hospital (GACH) 2 on 10/1/2025.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, personal, and oral hygiene, and dressing. During a review of Resident 1's History and Physical Examination (H&P), dated 9/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a telephone interview on 12/5/2025 at 12:10 PM with Resident 1, Resident 1 stated Resident 1 received Tramadol for pain while Resident 1 was at GACH 1. Resident 1 stated Resident 1 was transferred from GACH 1 to the facility. Resident 1 stated Resident 1 received pain medication during Resident 1's stay at the facility. Resident 1 stated Resident 1 thought Resident 1 had been receiving tramadol when Resident 1 requested pain medication. Resident 1 stated Resident 1 discovered Resident 1 had been given Norco and not tramadol when Resident 1 requested pain medication while at the facility. Resident 1 stated the nurses (unidentified) did not inform Resident 1 that the pain medication Resident 1 was given was Norco. During a concurrent interview and record review on 12/11/2025 at 9:19 AM with Registered Nurse (RN) 1, Resident 1's Discharge/Transfer Documentation (DTD), dated 9/10/2025, and Resident 1's physician orders, untitled, dated 9/10/25 and 9/11/2025 were reviewed. The DTD indicated Resident 1 had the following order while at GACH 1: Tramadol 50 milligram (mg, a unit of measurement) oral tablet every 12 hours as needed for pain. The DTD indicated Resident 1 should continue to take tramadol for pain while at the facility. A physician order dated 9/10/2025 indicated Resident 1 would continue to receive Tramadol as needed for pain while at the facility. A physician order, dated 9/11/2025, indicated the order for tramadol was changed for Norco on 9/11/2025 at 1:27 PM. RN 1 stated when a resident's (in general) pain medication is changed, the Resident (in general) should be notified, and the notification should be documented in the resident's (in general) medical record. RN 1 confirmed Resident 1's medical record failed to indicate Resident 1 was notified of the changed order for pain medication. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revised December 2016, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to. be informed of, and participate in, his or her care planning and treatment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to promptly notify Resident 1's doctor of Resident 1's complaint of pain and feeling that Resident 1's right hip was dislocated. This failure had the potential for Resident 1 to not receive timely treatment for pain and correction of the hip dislocation. (Cross Reference F552, F755, F806, and F842)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses including fracture (broken bone) of unspecified part of neck of right femur (thigh bone), dislocation of right hip (a medical emergency where the thigh bone pops out of the hip socket), and need for assistance with personal care. The AR indicated Resident 1 was discharged to General Acute Care Hospital (GACH) 2 on 10/1/2025.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, personal, and oral hygiene, and dressing. During a review of Resident 1's History and Physical Examination (H&P), dated 9/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a telephone interview on 12/5/2025 at 12:10 PM with Resident 1, Resident 1 stated that on 9/30/2025 at 5 AM, resident woke up and realized Resident 1 did not have the abductor pillow (a foam wedge placed between the thighs to keep legs aligned, preventing painful hip dislocation after surgery) between Resident 1's legs. Resident 1 stated Resident 1 reached over to grab the abductor pillow that was next to the bed. Resident 1 stated Resident 1 heard a pop and had instant pain to the right hip. Resident 1 stated Resident 1 had dislocated Resident 1's right hip. Resident 1 stated the facility should have sent Resident 1 to the hospital at that time. Resident 1 stated Resident 1 was not sent to a GACH until 10/1/2025.During a concurrent interview and record review on12/9/2025 at 10:38 AM with LVN 2, Resident 1's elNTERACT Change in Condition Evaluation (CIC), dated 9/30/2025 and timed 6:14 AM, was reviewed. The CIC was signed by Licensed Vocational Nurse (LVN) 2 on 10/1/2025. The CIC indicated, During med pass, patient (Resident 1) verbalized pain to right hip.pt (Resident 1) verbalized possible dislocation to right hip . LVN 2 stated LVN 2 texted Resident 1's Attending Physician (DR 1) but that DR 1 did not respond during LVN's remaining shift. LVN 2 stated LVN 2 did not try to contact DR 1 again on LVN 2's shift. LVN 2 stated LVN 2 left the facility at 7:00 AM on 9/30/2025.During a concurrent observation and interview on 12/10/2025 at 9:43 AM with Registered Nurse (RN) 1, the facility's Nurses Station iPhone was observed. RN 1 pulled up a text message that was sent to DR 1 on 9/30/2025 at 5:43 AM. The text message indicated, Pt (Resident 1) is verbalizing feels like hip has popped out of place, in a lot of pain.Patient (Resident 1) wants to be transferred to ER. Can we send? RN 1 confirmed DR 1 did not respond to the text message. RN 1 stated LVN 2 should have tried to contact DR 1 again after 1/2 hour. RN 1 stated the facility should have tried to contact the medical director if DR 1 did not respond.During a telephone interview on 12/10/2025 at 10:23 AM with DR 1, DR 1 stated, after looking at Dr 1's text messages from 9/30/2025, DR 1 did not receive the text message sent from the facility's iPhone at 5:43 AM. DR 1 stated DR 1 would have given an order to send Resident 1 to a GACH if he had received the text. DR 1 stated DR 1 ordered an Xray for Resident 1 when the facility notified DR 1 that Resident 1felt like Resident 1's hip was dislocated. During a review of Resident 1's Progress Notes dated 11/8/20256, the PN indicated DR 1 was made aware on 9/30/2025 at 2:33 PM, that Resident 1's had complaint in the previous shift of feeling Resident 1's hip had popped out of place. The PN indicated DR 1 ordered a right hip Xray.During a review of the facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, revised July 2017, the P&P indicated, The nursing staff will contact the physician based on the urgency of the situation. For emergencies, they will call or page the physician and request a prompt response (within approximately one-half hour or less).The attending physician (or a practitioner providing backup coverage) will respond.in a timely manner to notification of problems or changes in condition and status.The nursing staff will contact the medical director for additional guidance and consultation if they do not receive a timely or appropriate response.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide routine drugs for one of three sampled residents (Resident 1) when Resident 1 was not provided scheduled medications on 9/10/2025 at 9:00 PM. This failure had the potential to result in Resident 1 experiencing increased pain due to neuropathy (damage or dysfunction of nerves).(Cross Reference F552, F580, F806, and F842)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses including fracture (broken bone) of unspecified part of neck of right femur (thigh bone), dislocation of right hip (a medical emergency where the thigh bone pops out of the hip socket), and need for assistance with personal care. The AR indicated Resident 1 was discharged to General Acute Care Hospital (GACH) 2 on 10/1/2025.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, personal, and oral hygiene, and dressing. During a review of Resident 1's History and Physical Examination (H&P), dated 9/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a concurrent interview and record review on 12/11/2025 at 9:19 AM with Registered Nurse (RN) 1, Resident 1's Discharge/Transfer Documentation (DTD), dated 9/10/2025, and Resident 1's physician orders, untitled, dated 9/10/25 and 9/11/2025 were reviewed. The DTD indicated Resident 1 had orders for the following medications while at GACH 1: 1. bupropion SR (a medication used to treat depression) 150 milligram (mg, a unit of measurement) 12-hour by mouth (oral) tablet twice a day (BID)2. gabapentin (a medication used to treat neuropathy) 300 mg 1 cap oral three times a dayThe DTD indicated the next doses to be given for both medications was due 9/10/25 at 9:00 PM. RN 1 stated Resident 1 was admitted to the facility on [DATE] at 4:15 PM. RN 1 stated Resident 1 did not get the bupropion SR or gabapentin until the next day because the pharmacy does not process the medication until the following day. During an interview on 12/11/2025 at 11:06 AM with the Director of Nursing (DON), the DON stated Resident 1's medical record did not contain any documentation regarding a discussion with Resident 1's attending physician if the bupropion SR and gabapentin could be started the next day on 9/11/2025 and not given on 9/10/2025 at 9:00 PM. During a review of the facility's policy and procedure (P&P) titled, Providing Pharmacy Products and Services, revised 1/2/2013, the P&P indicated, If a medication cannot be substituted ask Physician/Prescriber if the medication therapy can be initiated the next morning. If it is possible to initiate the medication therapy the next morning, facility staff should document the conversation with the prescriber and include the start time in the order.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on interview and record review, the facility failed to ensure one of three sampled residents' (Resident 1) food allergy to bananas was:a. documented in Resident 1's assessment notes according to the facility's Policy and Procedure (P&P), titled Food Allergies and Intolerances, revised August 2017.b. Indicated on Resident 1's tray card (or tray ticket/meal ticket, a document that accompanies a resident's meal tray during preparation and delivery) according to the facility's P&P, titled Dietary Tray Card, revised 3/21/2024.These failures had the potential for Resident 1 to experience an allergic reaction to bananas.(Cross Reference F552, F580, F755, and F842)Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses including fracture (broken bone) of unspecified part of neck of right femur (thigh bone), dislocation of right hip (a medical emergency where the thigh bone pops out of the hip socket), and need for assistance with personal care. The AR indicated Resident 1 was discharged to General Acute Care Hospital (GACH) 2 on 10/1/2025. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, personal and oral hygiene, and dressing. During a review of Resident 1's History and Physical Examination (H&P), dated 9/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Skilled Nursing - Nutrition Risk Review Form (NRR), dated 9/11/2025, the NRR failed to indicate Resident 1 was allergic to bananas. During a review of Resident 1's Skilled Nursing - admission Initial Eval (AIE), the AIE failed to indicate Resident 1 was allergic to bananas. During a telephone interview on 12/5/2025 at 12:10 PM with Resident 1, Resident 1 stated Resident 1 was allergic to bananas. Resident 1 stated Resident 1's mouth would swell if Resident 1 ate bananas. Resident 1 stated the meal slip on Resident 1's meal trays listed bananas as a dislike. Resident 1 stated the allergy section on the meal slip was blank. During a concurrent interview and record review on12/10/2025 at 1:00 PM with the Dietary Supervisor, Resident 1's Skilled Nursing - Dietary Pre-Screen Eval (DPS), dated 9/11/2025, and Resident 1's untitled Tray Ticket document (TTD), undated, were reviewed. Both documents (DPS and TTD), failed to indicate Resident 1 had an allergy to bananas. The DS stated the DS was responsible to fill out the DPS and to update the TTD with Resident 1's allergies. The DS stated the TTD was the program used to create tray tickets that are placed on each resident's (in general) meal trays. The DS stated Resident 1 informed the DS that Resident 1 had an allergy to bananas in 10/11/2025. The DS stated the document would not let the DS put banana in the allergy fields, so the DS listed banana as a dislike. The DS stated allergies should be listed for safety of residents (in general). The DS stated the kitchen staff (in general) look at tray tickets when preparing meal trays for the residents (in general). During a review of the facility's P&P, titled Food Allergies and Intolerances, revised August 2017, the P&P indicated, Residents are assessed for a history of food allergies and intolerances upon admission and as part of the comprehensive assessment.All resident reported food allergies and intolerances are documented in the assessment notes and incorporated into the resident's care plan. During a review of the facility's P&P, titled Dietary Tray Card, revised 3/21/2024, the P&P indicated, The Food and Nutrition Services Department should maintain a tray card system in order to record dietary information necessary to use on the resident's tray card. The P&P indicated, The tray card should contain the following information on each resident.Any known allergies.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain a complete and accurate medical record for one of three sampled residents (Resident 1) when:a. Licensed Vocational Nurse (LVN) 2 failed to document Resident 1's acute condition change on 9/30/2025.b. LVN 2 documentation regarding Resident 1's acute condition change, which was recorded on 10/1/2025, contained inaccurate information. This failure resulted in Resident 1's medical record to contain inaccurate information, Registered Nurse (RN) 1 to not be aware of Resident 1's acute condition change, and had the potential for Resident 1 to not receive timely treatment for pain and correction of the hip dislocation (a medical emergency where the thigh bone pops out of the hip socket).(Cross reference F552, F580, F755, and F806)Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted Resident 1 on 9/10/2025 with diagnoses including fracture (broken bone) of unspecified part of neck of right femur (thigh bone), dislocation of right hip, and need for assistance with personal care. The AR indicated Resident 1 was discharged to General Acute Care Hospital (GACH) 2 on 10/1/2025.During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 1 was moderately impaired in cognitive skills (ability to make daily decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) on staff for toileting, personal, and oral hygiene, and dressing. During a review of Resident 1's History and Physical Examination (H&P), dated 9/11/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a telephone interview on 12/5/2025 at 12:10 PM with Resident 1, Resident 1 stated that on 9/30/2025 at 5 AM, resident woke up and realized Resident 1 did not have the abductor pillow (a foam wedge placed between the thighs to keep legs aligned, preventing painful hip dislocation after surgery) between Resident 1's legs. Resident 1 stated Resident 1 reached over to grab the abductor pillow that was next to the bed. Resident 1 stated Resident 1 heard a pop and had instant pain to the right hip. Resident 1 stated Resident 1 had dislocated Resident 1's right hip. During a concurrent interview and record review on12/9/2025 at 10:38 AM with LVN 2, Resident 1's elNTERACT Change in Condition Evaluation (CIC), dated 9/30/2025 and timed 6:14 AM, was reviewed. The CIC was signed by LVN 2 on 10/1/2025. The CIC indicated, pt (Resident 1) verbalized pain to right hip and possible dislocation. The CIC inaccurately indicated the event started on 10/1/2025. The CIC indicated, During med pass, patient (Resident 1) verbalized pain to right hip.pt (Resident 1) verbalized possible dislocation to right hip . LVN 2 stated the event happened on 9/30/25 early in the morning. LVN 2 stated LVN 2 texted Resident 1's Attending Physician (DR 1) but that DR 1 did not respond during LVN 2's remaining shift. LVN 2 stated LVN 2 did not create the CIC document until LVN 2's worked the next shift, on 10/1/2025. The CIC inaccurately indicated DR 1 was made aware of the incident on 9/30/2025 at 5:44 AM.During an interview on 12/10/2025 at 9:43 AM with Registered Nurse (RN) 1, RN 1 stated RN 1 was the RN supervisor who worked the morning shift after LVN 2 went home. RN 1 stated LVN 2 did not give report to RN 1 about Resident 1's complaint of pain and possible hip dislocation. RN 1 stated RN 1 was also not aware of the situation because LVN 2 did not complete a CIC before LVN 2 left the facility at the end of the shift.During a review of the facility's policy and procedure (P&P) titled, Acute Condition Changes - Clinical Protocol, revised July 2017, the P&P indicated, .the nurse shall assess and document/report the following baseline information:a. Vital signs;b. Neurological status;c. Current level of pain, and any recent changes in pain level;d. Level of consciousness;e. Cognitive and emotional status;f. Resident's age and sex;g. Onset, duration, severity;h. Recent labs;i. History of psychiatric disturbances, mental illness, depression, etc.;j. All active diagnoses; andk. All current medications.During a review of the facility's P&P titled, Charting and Documentation, revised July 2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.