STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555768	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Yorba Linda Post-Acute	17803 Imperial Highway Yorba Linda, CA 92886

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to ensure the sanitary condition of the hood over the stove was maintained. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and in good condition. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were kept in a sanitary condition and with cleanable surface. * The facility failed to ensure the heavy-duty blenders used for puree preparation, the clear rectangular plastic bucket containers used for marinating meats and food storage were air dried prior to storing and stacking and to ensure the blender was free of food residue prior to storing. * The facility failed to ensure the countertop mounted can opener was in sanitary condition and free of residue. * The facility failed to ensure the hair restraints was worn appropriately by the dietary aide. These failures had the potential for cross contamination and foodborne illnesses to the 41 of 41 residents consuming the foods prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 4/12/26, showed 41 of 41 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Hoods and Filters date revised 8/31/18, showed the hoods must be kept free of grease and dust at all times. Because of a potentially high fire hazard, it is important that hood filters be part of a strictly enforced cleaning schedule and be free of grease and dust at all times. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 4/12/26 at 0752 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The kitchen hood over the stove had black, dirt residue. The [NAME] acknowledged the findings and stated the [NAME] cleaned the hood once a week and the hood was also cleaned by an outside company. The sticker on the hood showed it was last serviced on 1/16/26. 2. Review of the facility's P&P titled Sanitization date revised 10/2008 showed all the utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning. Plastic ware, china and glassware that cannot be sanitized or are hazardous because of chips, cracks, or loss of glaze shall be discarded. Damaged or broken equipment that cannot be repaired shall be discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/12/26 at 0752 hours, during the initial kitchen tour, a (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	concurrent observation and interview was conducted with the Cook. The following was observed and verified by the Cook:- One black rubber spatula with black handle had heat erosion and cracked at the edge.- One black rubber spatula with black handle had cracked at the edge.- One stainless steel spatula with black handle partially melted.- One white basting brush with bristles frayed and worn out.- Two large white rubber spatulas with red handles had chipped and cracked edges.- Five small white rubber spatulas with red handles had chipped, cracked edges and discolored.- One stainless steel whisk had shape deformity. 3. Review of the facility's P&P titled Sanitization date revised 10/2008 showed all the equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/ or chemical sanitizing solutions. Further review of the facility's P&P titled Trayline Setup and Service date revised 7/2/18, showed all the dishware and utensils utilized on trayline should not be soiled. According to the USDA Food Code 2022, 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. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 4/12/26 at 0752 hours, during the initial kitchen tour, a concurrent observation and interview was conducted with the Cook. The following was observed and verified by the Cook:- Clear plastic container used for storage of utensils and kitchenware was observed dirty, fuzzy films with watermarks and had dry residue inside.- Two white plastic ketchup pumps were observed dirty and had dry, crusted residue.- Six stainless steel scoops with gray handles were observed dirty, had fuzzy films, watermarks and dry, crusted residue.- One stainless steel scoop with green handle had fuzzy films and watermarks.- Four stainless steel scoops with red handles had watermarks.- One stainless steel scoop with yellow handle had fuzzy films.- One stainless steel scoop with purple handle had dry, crusted residue.- One stainless steel scoop with white handle had fuzzy films and watermarks.- One white plastic serving spoon was observed dirty with dry, crusted residue.- Two stainless steel slotted spoons were observed dirty and had fuzzy films and dry, crusted residue.- One stainless steel spoon had fuzzy films and watermarks.- One stainless steel ladle was observed dirty and had fuzzy films and watermarks.- One black peeler was observed dirty and had dry residue.- One stainless steel knife with black handle had fuzzy films and dry watermarks. 4. Review of the facility's P&P titled Sanitization date revised 10/2008 showed the cutting boards (acrylic or hardwood) will be washed and sanitized between uses. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 4/12/26 at 0838 hours, during the initial kitchen tour, a concurrent observation was conducted with the Culinary Director. The white, brown, green, blue and yellow cutting boards were observed fuzzy, heavily marred and had deep groves. The Culinary Director verified the findings and stated the cutting boards should have been replaced. In addition, the Culinary Director stated she conducts her kitchen walk through every Monday and all worn out kitchenware and utensils should have been discarded and replaced, all dirty kitchenware and equipment should have been rewashed for sanitation purposes. 5. Review of the facility's P&P titled Sanitization date revised 10/2008 showed the food preparation equipment and utensils that are manually washed will be allowed to air dry whenever practical. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 4/13/26 at 0823 and 1058 hours, during the follow up kitchen visit, an observation and concurrent interview was conducted with the Cook. The following was observed and verified by the Cook:- One heavy-duty blender stored on the metal rack shelf was observed dirty, still wet with visible water and had white residue inside and on the lid.- Five rectangular clear bucket containers used for marinating meats and storage were observed wet with visible water inside and stacked on top of each other. The [NAME] verified the above findings and stated all the kitchen utensils and equipment should have been cleaned and air dried to prevent bacteria growth. 6. According to the USDA Food Code 2017, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/12/26 at 0838 hours, during the initial kitchen tour, a concurrent observation was conducted with the Culinary Director. The countertop mounted can opener was observed with dry, crusted black and white residue on the blade. The Culinary Director acknowledged the findings and verbalized it should have been washed and cleaned. 7. Review of the facility's P&P titled How Clean Is Your Uniform and Personal Hygiene date revised 1/11/19, showed all the staff in the Food and Nutrition Services department or staff coming into the department must wear hair restraints and should not be touching their hair and face while serving food. According to the USDA Food Code 2022, Section 2-402.11 Effectiveness (A), Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils . During the lunch meal tray line observation on 4/13/26 at 1123 hours, the Dietary Aide was serving lunch with facial hair not covered with a hair restraint. The RD verified the findings and beard guard was used. On 4/15/26 at 1202 hours, the DON was informed and acknowledged the above findings.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility's Consultant Pharmacist failed to identify and make recommendation for drug irregularities for three of 15 residents (final sampled Resident 19 and nonsampled Residents 17 and 30) reviewed for the medication administration. * Resident 17's drug regimen review failed to identify drug irregularities with the administration of levothyroxine sodium and lansoprazole (PPI medication used to treat GERD) together. * Resident 19's drug regimen review failed to identify drug irregularities with the administration of levothyroxine and pantoprazole sodium delayed release together. * Resident 30's drug regiment review failed to identify the drug irregularities with the administration of pantoprazole sodium delayed release (PPI medication used to treat GERD) and levothyroxine sodium (medication to treat hypothyroidism) together. These failures had the potential for the residents to not effectively absorb the ordered medication and potentially affect the residents' health.Findings: Review of the facility's P&P titled Medication Regimen Review revised 2/2025 showed the Consultant Pharmacist conducts a MRR for every resident in the facility receiving medications to minimize adverse consequences and a potential risk associated with medications. The MMR includes a review of the resident's medical record to prevent, identify, report, and resolve medication related problems, or other irregularities. Review of Mayo Clinic's recommendations for proper use of levothyroxine showed: - If you are using stomach medicine (e.g., lansoprazole, omeprazole, pantoprazole), or any medicine that contains calcium or iron, take them at least four hours before or four hours after you take the levothyroxine as they may reduce the absorption of the levothyroxine. Review of Drugs.com (an online resource) article for levothyroxine and pantoprazole use showed combining these medications pantoprazole may interfere with the absorption of oral levothyroxine sodium and reduce levothyroxine sodium's effectiveness. 1. Medical record review for Resident 30 was initiated on 4/12/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's Order Summary Report showed physician's order dated 3/25/26, for levothyroxine sodium 75 mcg by mouth daily before breakfast and pantoprazole sodium delayed release 40 mg by mouth daily before breakfast. Review of Resident 30's MAR for April 2026 showed the levothyroxine sodium and pantoprazole sodium delayed release medications were scheduled to be administered daily at 0630 hours. Review of the facility's Consultant Pharmacist Monthly MRR for April 2026 showed the Pharmacy Consultant conducted the MRR on 4/7/26. The MRR failed to identify the drug irregularities with the administration of Resident 30's pantoprazole sodium and levothyroxine sodium medications which were being administered at the same time. On 4/13/26 at 0559 hours, a medication administration observation for Resident 30 was conducted with LVN 1. LVN 1 administered the pantoprazole sodium delayed release 40 mg and levothyroxine (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sodium 75 mcg medications at the same time to Resident 30. 2. Medical record review for Resident 17 was initiated on 4/13/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed the following physician's orders dated 3/19/26, to administer levothyroxine sodium tablet 88 mcg by mouth in the morning on an empty stomach for low thyroid hormone and one delayed-release tablet of lansoprazole 30 mg by mouth one time a day before breakfast for GERD. Review of Resident 17's MAR for April 2026 showed the levothyroxine sodium and lansoprazole were scheduled to be administered daily at 0630 hours. Review of the facility's Consultant Pharmacist Monthly MRR for April 2026 showed the Pharmacy Consultant conducted the MRR on 4/7/26. The MRR failed to identify the drug irregularities with the administration of Resident 17's levothyroxine sodium and lansoprazole medications which were being administered at the same time. On 4/13/26 at 0527 hours, a medication administration observation for Resident 17 was conducted with LVN 5. LVN 5 administered the levothyroxine sodium 88 mcg and lansoprazole delayed release 30 mg medications at the same time to Resident 17. 3. Medical record review for Resident 19 was initiated on 4/13/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed a physician's orders dated 3/19/26, to administer levothyroxine sodium tablet 100 mcg by mouth in the morning on an empty stomach for low thyroid hormone and one delayed-release tablet of pantoprazole sodium 40 mg by mouth two times a day before breakfast and dinner for GERD. Review of Resident 19's MAR for April 2026 showed the levothyroxine sodium and pantoprazole sodium medications were scheduled to be administered daily at 0630 hours. Review of the facility's Consultant Pharmacist Monthly MRR for April 2026 showed the Pharmacy Consultant conducted the MRR on 4/7/26. The MRR failed to identify the drug irregularities with the administration of Resident 19's levothyroxine sodium and lansoprazole medications which were being administered at the same time. On 4/13/26 at 0553 hours, a medication administration observation for Resident 19 was conducted with LVN 5. LVN 5 administered the levothyroxine sodium 100 mcg and pantoprazole sodium delayed release 40 mg medications at the same time to Resident 19. On 4/13/26 at 1202 hours, a telephone interview was conducted with the Pharmacy Consultant. The Pharmacy Consultant stated there was not a concern with levothyroxine sodium being administered together with lansoprazole or pantoprazole medication. When asked about the lansoprazole medication affecting the absorption of the levothyroxine sodium medication when administered together, the Pharmacy Consultant stated she was not aware of any concerns but will research it. On 4/13/26 at 1223 hours, a follow-up interview was conducted with the Pharmacy Consultant. The (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Pharmacy Consultant stated she researched and stated the levothyroxine sodium medication should not be administered within four hours of any PPI, including the pantoprazole sodium and lansoprazole medications, and the order should be clarified by the physician to possibly change the administration times.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food items were served in the appetizing temperatures. * The food temperature was above the recommended temperature for cold beverages and below the recommended temperature for hot food. * Test tray temperatures were below the recommended temperature for hot meat and vegetables. These failures had the potential for the residents not to eat the food served and could affect the residents nutritional status for 41 of 41 residents who received food from the kitchen . Findings: Review of the facility's P&P titled Trayline Setup and Service date revised 7/2/18, showed food temperatures should be palatable for residents receiving room trays. Hot food should be 110-120 degrees Fahrenheit and cold food 45-50 degrees Fahrenheit. Review of the facility's Diet Type Report dated 4/12/26, showed 41 of 41 residents consumed the food prepared in the kitchen. Review of the facility's menu titled Week at a Glance dated 4/7/26, showed the lunch menu for 4/13/26, included mixed green salad with dressing, artichoke chicken, red bliss potatoes, seasoned green peas, bread or roll with margarine, chocolate cake with caramel icing, choice of beverage and herb roast beef for alternate. a. On 4/13/26 at 1123 hours, a tray line observation and concurrent interview was conducted with the RD and DSS. The RD and DSS checked and verified the mashed potatoes were at 100 degrees Fahrenheit, and the apple juice was at 54.8 degrees Fahrenheit. The RD acknowledged the apple juice temperature of 54.8 degrees Fahrenheit was above the recommended temperatures for cold beverage and the mashed potato temperature of 100 degrees Fahrenheit was below the recommended temperatures for hot food. b. On 4/13/26 at 1300 hours, a test tray observation of the regular lunch menu items and concurrent interview was conducted with the DSS and RD. The DSS checked and verified the roast beef was at 105.8 degrees Fahrenheit, and the green peas were at 94 degrees Fahrenheit. The DSS verified the roast beef and green peas temperatures were not hot and below the recommended temperatures for a hot meal tray. The DSS verified the findings.

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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, medical record review, and facility P&P review, the facility failed to ensure the medical records for five of 12 final sampled residents (Residents 2, 4, 10, 15, and 26) were accurate and complete. * The facility failed to ensure the POLST and social services notes contained the same information regarding the advance directive for Residents 2, 4, and 26. * The facility failed to ensure the social services assessment was completed upon admission for Resident 10. * The facility failed to ensure the behavior monitoring documentation was accurate for Resident 15. These failures had the potential for the residents' care needs not being met as their medical information were inaccurate and/or incomplete.Findings: Review of the facility's P&P titled Social Services Department revised 3/2022 showed the social services assessments are conducted to identify psychosocial, emotional, social, and discharge planning needs. A social services assessment shall be initiated upon admission and completed within seven days, and the assessment/evaluations may include, as appropriate, adjustment to placement, family or support system, resident preferences, behavior or mood concerns, coping status, communication needs, financial concerns, end-of-life preferences, advance directives, and the need for community resources or services. Review of the facility's P&P titled Advance Directives date revised 9/2022 showed under the section for If the Resident Has an Advance Directive, showed if the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed all documentation shall be complete and accurate and the medical record should facilitate communication between the IDT regarding the resident's condition and response to care. 1. Medical record review for Resident 26 was initiated on 4/12/26. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's POLST dated 3/18/26, under Section D, showed Resident 26 had an advance directive. However, there was no copy of the advance directive in Resident 26's medical records. Review of Resident 26's H&P examination dated 3/20/26, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's Social Services Progress notes dated 3/19 and 3/23/26, failed to show documentation if the information and formulation of an advance directive was offered to Resident 26. Review of Resident 26's Social Service Evaluation dated 3/20/26, showed Resident 26 had no advance directive. Review of Resident 26's admission MDS assessment dated [DATE], showed Resident 26 had a BIMS score of 15 (13-15 score suggests intact cognition). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/14/26 at 1434 hours, an interview and concurrent record review for Resident 26 was conducted with the SSD. The SSD acknowledged the above findings and stated Resident 26's POLST dated 3/18/26, and the Social Service Evaluation dated 3/20/26 did not match. Cross Reference to F578. 2. Medical record review for Resident 4 was initiated on 4/12/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's POLST dated 3/13/26, under Section D, showed Resident 4 had no advance directive. Review of Resident 4's admission MDS assessment dated [DATE], showed Resident 4 had a BIMS score of 12 (8-12 score suggest moderately impaired cognition). Review of Resident 4's Social Service Evaluation dated 3/17/26, showed Resident 4 had formulated an advance directive. However, Resident 4's medical record failed to show documentation if a copy of the advance directive had been requested. On 4/14/26 at 1629 hours, an interview and concurrent record review for Resident 4 was conducted with the SSD. The SSD acknowledged the above findings and stated the POLST dated 3/13/26 and Social Service Evaluation dated 3/17/26 did not match. On 4/15/26 at 1202 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 2 was initiated on 4/12/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's POLST dated 3/9/26, showed Resident 2 had no advance directive. Review of Resident 2's Social Service notes dated 3/10/26, showed Resident 2 had an advance directive in place, the type of advance directive was Healthcare Power of Attorney, and code status was DNR (Do Not Resuscitate). Review of Resident 2's Social Service notes dated 4/12/26 at 1308 hours, showed Resident 2 had no advance directives. On 4/14/26 at 1409 hours, an interview was conducted with the SSD. The SSD stated she documented Resident 2 as having an advanced directive; however, the SSD verified with the family that Resident 2 had no Advanced Directive. On 4/12/26 at 1509 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings. 4. Medical record review for Resident 10 was initiated on 4/12/26. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's medical record failed to show the social services assessment was (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed upon admission. On 4/12/26 at 1600 hours, an interview and concurrent medical record review for Resident 10 was conducted with the SSD. The SSD stated she would try to complete the social services assessments within 72 hours after admission. The SSD reviewed Resident 10 medical records and verified a social services assessment was not completed after Resident 10 was admitted to the facility on [DATE]. 5. Medical record review for Resident 15 was initiated on 4/12/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's MAR for April 2026 showed a physician's order dated 4/12/26, to monitor Resident 15's mood, behavior, and emotional status every shift. Further review of Resident 15's MAR showed for the night shift on 4/12/26, Resident 15 did not exhibit any behaviors. On 4/13/26 at 0510 hours, an interview was conducted with LVN 1. LVN 1 stated he was Resident 15's nurse during the night shift on 4/12/26, and Resident 15 had a few episodes of screaming during his shift. During the interview with LVN 1, a resident yelled out Oh God, I got to get out of here. LVN 1 stated that it was Resident 15 who just yelled out. On 4/13/26 at 0528 hours, an observation was conducted with Resident 15. Resident 15 was heard yelling out Oh, God! repeatedly. On 4/13/26 at 0532 hours, another observation was conducted for Resident 15. Resident 15 was heard screaming out Oh, God! I can't get out of bed! How am I going to get out? On 4/13/26 at 0533 hours, a CNA was observed going into the resident's room and Resident 15 could be heard shouting I don't give a damn! On 4/13/26 at 0744 hours, an interview and concurrent medical record review for Resident 15 was conducted with LVN 1. LVN 1 stated he had completed his documentation for the night shift and was ready to leave the facility. LVN 1 stated last night for his shift, Resident 15 had five or six episodes of screaming out, which started briefly at around 0200 hours, then the behavior increased at around 0400-0500 hours. LVN 1 reviewed Resident 15's MAR for April 2026 and verified the MAR showed Resident 15 had no behaviors on his shift. LVN1 stated he incorrectly documented in the MAR.

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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 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, and facility P&P review, the facility failed to maintain the infection prevention and control practices to help prevent the development and transmission of communicable diseases and infections. * LVN 5 failed to perform hand hygiene during the medication administration for 12 residents and blood glucose checks for seven residents. * LVN 5 failed to clean the glucometer between use for seven residents. * LVN 5 utilized an alcohol swab from the floor of an isolation room to wipe blood from the finger of Resident 35. These failures posed the risk for transmission of disease-causing microorganisms and infections to the resident, staff, and visitors.Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the following:- medications are administered in a safe and timely manner, and as prescribed; and- staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. Review of the facility's P&P titled Obtaining a Fingerstick Glucose Level revised 10/2011 showed the following:- the purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level;- equipment and supplies: disinfected blood glucose meter (glucometer) with sterile lancet; and- steps in the procedure: always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.wash hands. On 4/13/26 at 0515 hours, a medication observation was conducted with LVN 5. The following was observed:- Before beginning the medication administration, LVN 5 requested to step away to get a drink of water. LVN 5 went outside and returned to his medication cart to begin medication administration. LVN 5 did not perform hand hygiene upon returning to begin medication administration;- at 0520 hours, LVN 5 began the medication administration process; and from 0520 hours and 0644 hours, LVN 5 administered medications to 12 separate residents, which included performing blood glucose checks on seven of the 12 residents. LVN 5 did not perform hand hygiene between administering the medications and blood glucose checks to the residents. Additionally, LVN 5 did not disinfect the glucometer in between checking the blood glucose levels for the seven residents.- at 0610 hours, LVN 5 was observed performing a blood glucose check on Resident 35 who was on EBP isolation. LVN 5 placed the necessary supplies on the bedside table and dropped an unopened alcohol swab on the floor. LVN 5 picked up the alcohol swab with gloved hands and placed the alcohol swab on Resident 35's bedside table and proceeded to perform the blood glucose check. LVN 5 poked Resident 35's finger and wiped the first drop of blood with his gloved finger. After obtaining the blood sample, LVN 5 picked up the contaminated alcohol swab and used it to clean Resident 35's finger. On 4/13/26 at 0644 hours, an interview was conducted with LVN 5. LVN 5 verified he did not perform hand hygiene during his medication administration and stated he should be performing hand hygiene before entering a resident's room, upon exiting, and anytime his hands were visibly soiled. LVN 5 verified a lack of hand hygiene increases the risk for cross contamination between residents. LVN 5 verified he was supposed to disinfect the glucometer after every use and did not clean it during the entirety of his medication administration. LVN 5 verified he should not have used the alcohol swab he dropped on the floor because of risk of contamination to Resident 35. On 4/14/26 at 1134 hours, an interview was conducted with the DON. The DON stated during medication administration, nurses should be performing hand hygiene at cart before medication preparation, anytime they touch anything, before going into the resident's room and upon exiting. The DON verified the alcohol swab dropped on Resident 35's floor should have been discarded. The DON stated the glucometer should be disinfected after each use.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to inform and provide the written information regarding the rights to formulate the advance directive to one of 12 final sampled residents (Resident 26). * The facility failed to ensure the information and formulation of an advance directive was offered to Resident 26. This failure had the potential to violate the resident's rights to decline or formulate an advanced directive and for the resident's healthcare preferences not honored.Findings: Review of the facility's P&P titled Advance Directives date revised 9/2022 showed the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with the state law and facility policy. In addition, under the section for If the Resident Does not have an Advance Directive showed, if the resident or representative indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. Medical record review for Resident 26 was initiated on 4/12/26. Resident 26 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 26's H&P examination dated 3/20/26, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's admission MDS assessment dated [DATE], showed Resident 26 had a BIMS score of 15 (13-15 suggests intact cognition). Review of Resident 26's POLST dated 3/18/26, showed under Section D, Resident 26 had an advanced directive. However, further review of Resident 26's medical records failed to show a copy of the advance directive in Resident 26's medical records. Review of Resident 26's Social Service Evaluation dated 3/20/26, showed Resident 26 had no advanced directive and information was only provided on his right to formulate an advance directive on 4/14/26. Further review of Resident 26's Social Services Progress notes dated 3/19 and 3/23/26, failed to show a documentation if the information and formulation of an advance directive was offered to Resident 26. On 4/14/26 at 1434 hours, an interview with concurrent medical record review was conducted with the SSD. The SSD verified the above findings and stated there was no documentation if an advance directive was offered to Resident 26. On 4/15/26 at 1202 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross Reference to F842 #1.

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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, record review, and facility P&P review, the facility failed to ensure the prescriber documented an appropriate clinical rationale for the continued use of the psychotropic medication for one of five final sampled residents (Resident 15) reviewed for unnecessary medications. * The facility failed to ensure an appropriate clinical rationale for Resident 15's continued use of the PRN zolpidem (a psychotropic sedative used to treat insomnia) was documented. This failure had the potential for the Resident 15 to receive unnecessary psychotropic medication and could negatively impact the resident's health outcomes and well-being.Findings: Review of the facility's P&P titled Psychotropic Medication Use dated July 2022 showed PRN psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, the prescriber will document the rationale for extending the use. Medical record review for Resident 15 was initiated on 4/12/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's MAR for April 2026 showed the following physician's order:- dated 3/21/26, to administer zolpidem tartrate 5 mg by mouth at bedtime PRN for insomnia, with an order duration of 14 days; and- dated 4/7/26, to administer zolpidem tartrate 5 mg by mouth at bedtime PRN for insomnia, with an order duration of 14 days. Review of Resident 15's nursing Progress Notes dated 4/6/26 at 2350 hours, showed Resident 15's physician was notified of the resident's request to extend the PRN zolpidem tartrate medication, and the physician agreed to extend the medication for an additional 14 days. Further review of Resident 15's medical record failed to show an appropriate clinical rationale for continued use of the zolpidem tartrate medication. On 4/14/26 at 1342 hours, an interview and concurrent medical record review for Resident 15 was conducted with RN 1. RN 1 reviewed Resident 15's medical record and verified the record failed to show documentation for the continued use of zolpidem tartrate beyond the original order of 14 days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the person-centered care plan for the use of the psychotropic medications were complete for one of 12 final sampled residents (Resident 15). * The facility failed to ensure the care plan included the specific targeted behavior monitoring for Resident 15's use of zolpidem tartrate (a psychotropic sedative used to treat insomnia) and buspirone HCl (antianxiety) medications. This failure posed the risk of not providing appropriate, consistent, and individualized care to the resident.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised December 2016 showed a comprehensive person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs will be developed for each resident. The care plan will incorporate identified problem areas and reflect treatment goals, timetables and objectives in measurable outcomes. Medical record review for Resident 15 was initiated on 4/12/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's MAR for April 2026 showed the following physician's orders:- dated 3/21/26, to administer zolpidem tartrate 5 mg by mouth at bedtime PRN for insomnia, with an order duration of 14 days and buspirone HCl 15 mg by mouth twice a day for anxiety; and- dated 4/7/26, to administer zolpidem tartrate 5 mg by mouth at bedtime PRN for insomnia, with an order duration of 14 days. Review of Resident 15's Behavior/Side Effects Monitoring Record for April 2026 showed the physician's orders dated 3/21/26, for the following:- to monitor anxiety as manifested by verbalization of feeling anxious every shift, for buspirone HCl use; and- to monitor for insomnia and the ability to fall asleep every evening and night shift, for zolpidem use. Review of Resident 15's Care Plan Report failed to address Resident 15's specific targeted behaviors of verbalization of feeling anxious for buspirone HCl medication use and insomnia and the ability to fall asleep for zolpidem tartrate medication use. On 4/13/26 at 0920 hours, an interview and concurrent medical record review for Resident 15 was conducted with the DON. The DON reviewed Resident 15's Care Plan Report and verified Resident 15's care plan failed to address the behavior monitoring for Resident 15's for specific targeted behaviors for the zolpidem tartrate and buspirone HCl medications use.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, medical record review, and facility P&P review, the facility failed to ensure the proper IV care was provided for one of one final sampled residents (Resident 19) receiving IV infusions. * The facility failed to ensure Resident 19's PICC line dressing was changed every seven days and Resident 19's IV infusion tubing was labeled. These failures posed the risk for Resident 19 developing complications related to IV infusions.Findings: Review of the facility's P&P titled Central Venous Catheter Dressing Changes revised 4/2016 showed the following:- The purpose of this procedure is to prevent catheter-related infections that are associated with contaminated, loosened, soiled, or wet dressings; and- Change transparent semi-permeable membrane dressings at least every 5-7 (five to seven) days and PRN (when wet, soiled, or not intact). Review of the facility's P&P titled Administration Set/Tubing Changes revised 10/2024 showed the purpose of this procedure is to provide guidelines for aseptic administration set changes in order to prevent infections associated with contaminated IV therapy equipment:- Label tubing with date, time, and initials.- Any tubing that is found not labeled must be changed and then labeled accordingly. On 4/12/26 at 0851 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 19. Resident 19 was sitting up in bed. Resident 19 was observed to have an IV pole at the bedside with two IV bags hanging from the pole. The first IV bag was labeled NS (normal saline) 0.9% 1000 mL IV solution dated 4/11, and the bag was connected to unlabeled IV tubing. The IV NS bag was not connected to Resident 19. The second IV bag was labeled cefepime-dextrose 2 gm/50 mL (antibiotic). The cefepime bag was connected to a tubing with a green label which showed the IV set was good for 24 hours, the RN initials, start date and time of 4/12 at 0700 hours, and a discard date and time of 4/13 at 0700 hours. The cefepime bag was connected to Resident 19; however, the infusion was completed. Resident 19 stated he was receiving IV antibiotics and IV hydration through a PICC line. An observation of the PICC line showed a dressing with a hand-written date of 4/2/26. Medical record review for Resident 19 was initiated on 4/12/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 3/21/26, showed Resident 19 had the capacity to understand and make decisions. Review of Resident 19's Order Summary Report dated 4/14/26, showed a physician's order - dated 3/18/26, Cefepime Hcl 2 gm per 100ml, intravenously two times a day and - dated 3/27/26, for PICC dressing change - site: right upper arm - use IV dressing kit, perform dressing site care and change cap every seven days and PRN. On 4/12/26 at 1559 hours, a follow up observation was conducted for Resident 19. Resident 19 was observed sitting up in bed. Resident 19 was connected to the IV NS bag with a set rate to infuse at 50 mL/hr. During this observation, the IV NS IV solution bag was dated 4/11 and now the IV tubing had a green label dated 4/12 at 0800 hours. On 4/12/26 at 1601 hours, an interview and concurrent record review for Resident 19 was conducted with RN 2 and the DON. RN 2 verified Resident 19 had an order for three liters of IV hydration of NS to be infused at 50 ml/hr. RN 2 stated the third liter of NS was started on 4/11/26, and would complete on 4/12/26. RN 2 stated Resident 19's medical record showed the PICC line dressing was changed on 4/9/26. The DON stated the process for dating the PICC line dressings was to date the dressing on the day it was changed. The DON also stated the IV lines should be labeled when they were changed or every 72 hours as per the facility policy. On 4/12/26 at 1615 hours, an observation for Resident 19 and concurrent interview was conducted with the DON. The DON verified the date of Resident 19's PICC line dressing was 4/2/26. The DON further stated if the PICC line dressing was dated 4/2/26, then the PICC line dressing was never changed. Further observation of Resident 19 was conducted with the DON. The DON verified the IV NS bag was dated 4/11 but the IV tubing had a green label dated 4/12 at 0800 hours. When asked how the IV NS line had a label date the day after the infusion was started, the DON stated she called RN 1 earlier that morning and instructed him to ensure all the IV lines were labeled; however, the DON refused to make (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any further comments regarding the label on the IV tubing and stated she should speak to RN 1 who was responsible for labeling the IV tubing. On 4/13/26 at 0837 hours, an interview was conducted with RN 1. RN 1 stated the purpose of labeling the IV tubing was to indicate when the IV tubing was changed and when it expires. RN 1 stated he conducted rounds the day prior and observed Resident 19's IV NS tubing was not labeled. RN 1 stated he added a label dated 4/12 to Resident 19's IV NS tubing and verified the IV NS bag was dated 4/11. RN 1 stated he did not replace the IV tubing, he just added a green label. RN 1 stated this was not following procedure because incorrectly dating the IV tubing can potentially cause the tubing to be used past the expiration date.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the necessary respiratory care and services for two nonsampled residents (Residents 17 and 52) reviewed for respiratory care. * The facility failed to ensure Residents 17 and 52 were provided the humidifier attached to the concentrator for the use of continuous oxygen therapy. This failure posed the risk for the residents to have nasal dryness and throat irritation. Findings: Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed in part, the purpose of this procedure is to provide guidelines for safe oxygen administration. Under the section for Steps and Procedure, showed check the mask, tank, humidifying jar, etc to be sure they are in good working order and are secularly fastened. Periodically re-check water level in humidifying jar. 1. On 4/12/26 at 0918 hours, during the initial tour of facility, an observation was conducted for Resident 52. Resident 52 was observed on her bed receiving oxygen therapy at a rate of 2 liters per minute via nasal canula. The oxygen concentrator was observed with no humidifier bottle. On 4/13/26 at 0805 hours, follow up observation was conducted for Resident 52. Resident 52's oxygen administration showed no humidifier connecting the concentrator into the resident's nostrils. On 4/13/26 at 0903 hours, interview was conducted with the DON. The DON stated if the oxygen was being administered continuously, the residents would need a humidifier to prevent dryness of the nostrils, no matter what the concentration of the oxygen was. Medical record review for Resident 52 was initiated on 4/13/26. Resident 52 was admitted to the facility on [DATE], with diagnosis of Acute Respiratory failure with Hypoxia. Review of Resident 52's Order Summary Report dated 4/14/26, showed a physician's order dated 4/10/26, for oxygen therapy continuously at a rate of 2 liters per minute via nasal cannula/mask, to maintain O2 sats (saturations) > 90%, contact MD if the O2 sats < 90%, and monitor the oxygen humidifier bottle every shift, change when bottle is close to empty every shift. On 4/13/26 at 0917 hours, interview with LVN 3 was conducted. LVN 3 stated humidifier should be replaced when it was empty. LVN 3 verified Resident 52's oxygen concentrator had no humidifier. On 4/15/25 at 1130 hours, interview was conducted with the DON. The DON was made aware and acknowledged the findings. 2. On 4/12/26 at 0952 hours, during the initial tour of the facility, an observation was conducted for Resident 17. Resident 17 was observed in bed on oxygen therapy via nasal cannula. The oxygen was observed set at a rate of 2 liters per minute with no humidifier bottle present. Medical record review for Resident 17 was initiated on 4/12/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's POLST dated 3/20/26, showed Resident 17 had the capacity to understand and make decisions. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/13/26 at 0906 hours, a follow up observation was conducted for Resident 17. Resident 17 was observed sitting in her chair wearing a nasal cannula. The oxygen was observed to be set at a rate of 2 liters with no humidifier bottle present. Review of Resident 17's Order Summary Report dated 4/14/26, showed the following physician's orders: - dated 3/19/26, to monitor the oxygen humidifier bottle every shift and change when the bottle was close to empty; and - dated 3/23/26, to administer oxygen therapy continuously at a rate of 2 liters per minute via nasal cannula every shift. On 4/13/26 at 1508 hours, an observation and concurrent interview and record review for Resident 17 was conducted with RN 1. RN 1 verified Resident 17 did not have a humidifier connected to the continuous oxygen. RN 1 verified there was an order to monitor the oxygen humidifier, and nurses had been marking the monitoring as completed without a humidifier present. On 4/14/26 at 1134, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **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 necessary care of the dialysis access site was provided for one of 12 final sampled residents (Resident 4). * The facility failed to ensure Resident 4's dialysis access site was consistently and accurately assessed pre and post hemodialysis treatments. This failure had the potential for delay in identifying complications related to the resident's dialysis access site.Findings: Review of the facility's P&P titled Care of a Resident with End-Stage Renal Disease date revised 9/2010 showed the residents with End-Stage Renal Disease (ESRD) will be cared for according to currently recognized standards of care. Further review of the facility's P&P titled Access and Care of Hemodialysis Catheters revised 2/2023 showed to check for signs of infection (warmth, redness, tenderness or edema) at the access site when performing routine care and at regular intervals. Check the color and temperature of the fingers, and the radial pulse of the access arm when performing routine care and at regular intervals. Check patency of the site at regular intervals. Palpate the site to feel the thrill, or use a stethoscope to hear the whoosh or bruit of blood flow through the access. Medical record review for Resident 4 was initiated on 4/12/26. Resident 4 was admitted to the facility on [DATE]. Resident 4 had a diagnosis of End Stage Renal Disease which required hemodialysis. Review of Resident 4's Order Summary Report showed a physician's order dated 3/13/26, to check AV shunt for presence of bruit and thrill every shift, if negative notify the physician. Review of Resident 4's admission MDS assessment dated [DATE], showed Resident 4 had a BIMS score of 12 (8-12 means moderately impaired cognition). Review of Resident 4's Care Plan Report showed a care plan focus problem addressing Resident 4's hemodialysis treatment and access site located on the left upper extremity AVF dated 3/13/26. The interventions included to keep the dialysis access site clean and dry, monitor for redness, poor circulation as evidenced by decrease in bruit and thrill or absent, swelling, or drainage and report the abnormalities to the physician. Review of Resident 4's Dialysis Communication Forms for March and April 2026 showed the following:- dated 3/20/26, the dialysis access at the left upper arm was assessed for bruit and thrill pre dialysis; however, the form failed to show if the site was assessed for warmth, edema, drainage and bleeding; - dated 3/20/26, the dialysis access at the left upper arm was not assessed for bruit and thrill and for color, warmth and drainage post dialysis; and - dated 4/10/26, the dialysis access at the left arm was not assessed for bruit and thrill and for color, warmth, drainage, bleeding and edema post dialysis. On 4/15/26 at 1023 hours, an interview and concurrent medical record review was conducted with LVN 6. LVN 6 stated the licensed nurses were responsible for the assessment and documentation in the Dialysis Communication Form. LVN 6 verified the above findings and stated the dialysis site should have been assessed pre and post dialysis to ensure AVF was working. On 4/15/26 at 1202 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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	555768	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Yorba Linda Post-Acute	17803 Imperial Highway Yorba Linda, CA 92886

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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 observation, interview, and medical record review, the facility failed to provide the pharmaceutical services to ensure for accurate reconciliation and administration of the medications for one of 12 final sampled residents (Resident 55). * The facility failed to ensure the Lasix (a diuretic medication) order for Resident 55 listed the appropriate indication for use. This failure had the potential for the resident's needs not being met as the indication of the medication use was incorrect.Findings: Medical record review for Resident 55 was initiated on 4/12/26. Resident 55 was admitted to the facility on [DATE]. Review of Resident 55's H&P examination dated 4/9/26, showed Resident 55 had the capacity to understand and make decisions. On 4/12/26 at 1119 hours, an observation and concurrent interview was conducted with Resident 55. Resident 55 stated she was having trouble sleeping due to the edema in her legs. Resident 55's lower legs were observed with edema was present. Review of Resident 55's Telephone Orders sheet showed a physician's order dated 4/10/26, for Lasix 20 mg one tablet by mouth daily, give first dose today for four days. Review of Resident 55's MAR for April 2026 showed the following orders and administration: - Lasix oral tablet 20 mg (furosemide), give one tablet by mouth one time only for pain during urination until 4/10/26 at 2359 hours, to give the first dose today (4/10/26). The MAR showed the Lasix medication was administered on 4/10/26 at 2154 hours; and- Lasix oral tablet 20 mg (furosemide), give one tablet by mouth one time a day for pain during urination for three days, to give the first dose today (4/11/26). The MAR showed the Lasix medication was administered on 4/11, 4/12, and 4/13/26 at 0900 hours by LVN 3. Further review of Resident 55's medical record showed the telephone order dated 4/10/26, did not have an indication for the use of the Lasix medication. On 4/14/26 at 1134 hours, an interview and concurrent record review for Resident 55 was conducted with the DON. The DON stated the indications for the Lasix medication was for a diuretic effect used for the residents with excess fluid and it was not indicated for urinary pain. The DON reviewed Resident 55's Lasix medication order and verified the indications were incorrect and stated the nurse should have called the physician to clarify the order. On 4/14/26 at 1435 hours, an interview and concurrent medical record review for Resident 55 was conducted with LVN 3. LVN 3 stated the Lasix medication was used as a diuretic and was not used for urinary pain. LVN 3 stated he should have questioned the indication on the order and contacted the physician to clarify the order prior to administering the Lasix medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 20%. Two of four licensed nurses (LVNs 1 and 5) who were observed during medication administration were found to have errors. * LVN 5 failed to ensure medications levothyroxine (medication to treat underactive thyroid) and pantoprazole/lansoprazole (medication to relieve stomach acids) were administered a minimum of four hours apart for Residents 17 and 19 * LVN 5 crushed a delayed release medication (pantoprazole) for Residents 2 and 46 * LVN 1 failed to ensure Resident 30's levothyroxine sodium and pantoprazole sodium medications were not administered together. These failures created the risk for the residents to have potential side effects or complications related to the medications.Findings: 1.a. Review of Mayo Clinic's online recommendations dated 3/31/26, for proper use of the levothyroxine medication showed: - If you are using stomach medicine (e.g., lansoprazole, omeprazole, pantoprazole), or any medicine that contains calcium or iron, take them at least four hours before or four hours after you take levothyroxine as they may reduce the absorption of the levothyroxine. On 4/13/26 at 0527 hours, a medication administration observation for Resident 17 was conducted with LVN 5. LVN 5 prepared and administered the following medications to Resident 17: - Xopenex (medication to treat wheezing and shortness of breath) 1.25 mg; - levothyroxine 88 mcg one tablet; and - lansoprazole delayed release 30 mg one capsule. Medical record review for Resident 17 was initiated on 4/13/26. Resident 17 was readmitted to the facility on [DATE]. Review of Resident 17's Order Summary Report showed the following physician's orders dated 3/19/26, for: - levothyroxine sodium tablet 88 mcg by mouth in the morning on an empty stomach for low thyroid hormone. - lansoprazole delayed release tablet 30 mg one tablet by mouth one time a day before breakfast for GERD (acid reflux condition). - Xopenex concentrate inhalation nebulizing solution 1.25 mg / 0.5 ml via nebulizer every six hours. b. On 4/13/26 at 0553 hours, a medication administration observation for Resident 19 was conducted with LVN 5. LVN 5 prepared and administered the following medications to Resident 19: - levothyroxine 100 mcg one tablet; and - pantoprazole 40 mg one tablet. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review for Resident 19 was initiated on 4/13/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's Order Summary Report showed the following physician's orders dated 3/19/26, for: - levothyroxine sodium tablet 100 mcg by mouth in the morning on an empty stomach for low thyroid hormone. - pantoprazole sodium delayed release 40 mg one tablet by mouth two times a day before breakfast and dinner for GERD. 2. a. Review of Mayo Clinic's online recommendations dated 3/31/26, for crushing delayed-release, extended-release, or sustained-release medications showed: Mayo Clinic strongly advises against crushing these medications as it damages the mechanism designed to release medicine slowly, potentially causing an overdose or rapid, ineffective absorption. Always swallow these tablets or capsules whole. On 4/13/26 at 0635 hours, a medication administration observation for Resident 2 was conducted with LVN 5. LVN 5 prepared and administered the following medications to Resident 2: - pantoprazole delayed release 40 mg one tablet During the medication administration, Resident 2 requested for the pantoprazole medication to be crushed and mixed with applesauce. LVN 5 returned to his medication cart, crushed the pantoprazole medication, mixed it with applesauce, and administered the medication to Resident 2. Medical record review for Resident 2 was initiated on 4/13/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MAR for April 2026 showed the following physician's order dated 3/7/26, for: - pantoprazole sodium delayed release 40 mg by mouth one tablet in the morning for GERD. b. On 4/13/26 at 0600 hours, a medication administration observation for Resident 46 was conducted with LVN 5. LVN 5 prepared and administered the following medications to Resident 46: - pantoprazole delayed release 40 mg one tablet. During the medication administration, LVN 5 stated Resident 46 had trouble swallowing the medication. LVN 5 proceeded to crush the pantoprazole medication, mixed it with applesauce, and administered the medication to Resident 46. Medical record review for Resident 46 was initiated on 4/13/25. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's MAR for April 2026 showed the following physician's order dated 3/20/26, for: (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- pantoprazole sodium delayed release 40 mg by mouth one tablet in the morning for GERD. On 4/13/26 at 0644 hours, an interview was conducted with LVN 5. LVN 5 stated he did not have a physician's order to crush the pantoprazole medication for Residents 2 and 46. LVN 5 verified he should not be crushing delayed-release medications because it affected how the medication was released and should have called the physician to change the medication order. On 4/13/26 at 1201 hours, a telephone interview was conducted with the Consultant Pharmacist. The Pharmacy Consultant stated the facility should not be crushing delayed-release medications like the pantoprazole medication. The Pharmacy Consultant stated the facility should call the physician and have the order changed to the pantoprazole granules which can be mixed with applesauce. On 4/13/26 at 1225 hours, a follow up telephone call from the Consultant Pharmacist was received. The Pharmacy Consultant verified the administration of the pantoprazole and lansoprazole medications should be separated by a minimum of four hours. The Pharmacy Consultant stated the levothyroxine medication should be given on an empty stomach and the facility should call the physician to reschedule the pantoprazole and lansoprazole medications. On 4/14/26 at 1134 hours, an interview was conducted with the DON. The DON verified the above findings. 3. Medical record review for Resident 30 was initiated on 4/12/26. Resident 30 was admitted to the facility on [DATE]. Review of Resident 30's Order Summary Report showed a physician's order dated:- 3/25/26, for levothyroxine sodium 75 mcg by mouth daily before breakfast.- 3/25/26, for pantoprazole sodium delayed-release 40 mg by mouth daily before breakfast. Review of Drugs.com, an online resource, showed the pantoprazole sodium medication may interfere with the absorption of the levothyroxine sodium medication and reduce the medications effectiveness. On 4/13/26 at 0559 hours, a medication pass observation was conducted with LVN 1. LVN 1 administered the pantoprazole sodium delayed release 40 mg and levothyroxine sodium 75 mcg medications to Resident 30. On 4/13/26 at 1223 hours, a follow-up interview was conducted with the Consultant Pharmacist. The Consultant Pharmacist stated she researched it and stated the levothyroxine sodium medication should not be administered within four hours of any PPI, including the pantoprazole sodium medication, and the order should be clarified by the physician to possibly change the administration times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were store in a safe manner for one of 12 final sampled residents (Resident 55), one nonsampled resident (Resident 56) and in one of two medication carts (Medication Cart B). * LVN 5 failed to ensure Residents 55 and 56's medications were safely stored during the medication administration. This failure posed the risk for unauthorized individuals to have access to the medication. * An open foil packet of Sorbalgon Ag (Ca Alginate Ag) wound dressing was stored in Medication Cart B. This failure had the potential for residents to receive medications that was contaminated and/or losing stability and effectiveness.Findings: 1. Review of the facility's P&P titled Administering Medications revised 4/2019 showed during administration of the medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart. a. On 4/13/26 at 0540 hours, a medication administration observation for Resident 55 was conducted with LVN 5. LVN 5 was observed preparing a medication and entered Resident 55's room to administer a medication. LVN 5 left a vial of insulin on top of the medication cart unattended. The medication cart was in the hallway. b. On 4/13/26 at 0543 hours, a medication administration observation for Resident 56 was conducted with LVN 5. LVN 5 was observed preparing the medication and entered Resident 56's room to administer the linaclotide (medication to treat constipation) medication. LVN 5 left a bubble pack of the linaclotide medication on top of the medication cart unattended. Several staff members and residents were observed in the hallway, in addition to an outside maintenance vendor who was replacing the sink in the kitchen. On 4/13/26 at 0644 hours, an interview was conducted with LVN 5. When asked about the medications left on top of the medication cart, LVN 5 stated he was supposed to lock medications in the cart whenever he walked away from the medication cart. On 4/14/26 at 1134 hours, an interview was conducted with the DON. The DON stated medications should never be left unattended on top of a medication cart and should always be securely locked in the medication cart when the nurse walks away. 2. On 4/14/26 at 1450 hours, an inspection of Medication Cart B was conducted with LVN 2. Medication Cart B contained a box of Sorbalgon Ag (is a sterile, antimicrobial dressing used to manage moderate to heavily exuding, infected, or infection-prone wounds) with each dressing individually wrapped in foil pouches. However, one of the foil pouches was open with a dressing inside. LVN 2 verified the open foil pouch of Sorbalgon Ag dressing. LVN 2 stated the dressing should have been thrown away and not stored in the cart.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu was followed for three of 41 residents that consumed the foods prepared in the kitchen. * The facility failed to provide bread or roll with margarine to Resident 30 as per her meal ticket. * The facility failed to provide bread or roll with margarine to Resident 36 as per his meal ticket. * The facility failed to provide mashed potatoes to Resident 33 as per her meal ticket. These failures had the potential for the residents to not receive adequate nutrition and appropriate servings to meet their individual needs.Findings: Review of the facility's Diet Type Report dated 4/12/26, showed 41 of 41 residents consumed the foods prepared in the kitchen. Review of the facility's menu titled Week at a Glance dated 4/7/26, showed the lunch menu for 4/12/26, included mixed green salad with dressing, bacon meatloaf, scalloped potatoes, sauteed broccoli florets, bread or roll with margarine, cherry cheesecake, and choice of beverage. Review of the facility's P&P titled Trayline Setup and Service date revised 7/2/18, showed according to the diet called, the main plate is served from the steam table and covered. The therapeutic spreadsheets are posted on trayline and are followed. Portions are adhered to by following scoop sizes noted on the menu. Bread, salads, desserts, and any special items are placed on the tray and sent down the trayline. The therapeutic spreadsheets are followed for these items. 1. On 4/12/26 at 1317 hours, during the dining observation, Resident 30 was observed eating her lunch in the dining room. Review of Resident 30's meal ticket showed her menu included mixed green salad with ranch dressing, bacon meatloaf, scalloped potatoes, sauteed broccoli florets, bread or roll with margarine, cherry cheesecake and diet cola. Resident 30 was served mixed green salad with ranch dressing, bacon meatloaf, scalloped potatoes, sauteed broccoli florets and diet cola; however, Resident 30 was not served the bread or roll with margarine from the menu. 2. On 4/12/26 at 1313 hours, during the dining observation, Resident 36 was observed eating his lunch in the dining room. Review of Resident 36's meal ticket showed his menu included mixed green salad, bacon meatloaf, scalloped potatoes, sauteed broccoli florets, bread or roll with margarine, cookie and lemon tea. Resident 36 was served mixed green salad, bacon meatloaf, scalloped potatoes, sauteed broccoli florets, water and tea; however, Resident 36 was not served the bread or roll with margarine from the menu. On 4/12/26 at 1317 hours, an observation and concurrent interview was conducted with the RD. The RD verified Residents 30 and 36 did not receive the bread or roll with margarine and stated it should have been provided to both residents. 3. On 4/12/26 at 1310 hours, a dining observation and concurrent interview was conducted with Resident 33. Resident 33 was observed eating her lunch in her room. Review of Resident 33's meal ticket showed she requested bacon meatloaf, soft sauteed broccoli florets, mashed potatoes, and diet cola. Resident 33 was served bacon meatloaf, soft sauteed broccoli florets, and diet cola. Resident 33 stated she did not receive the scalloped potatoes from the menu or the mashed potatoes she requested as a replacement. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/12/26 at 1322 hours, an interview and concurrent menu ticket observation was conducted with the RD. The RD verified Resident 33 requested mashed potatoes on the menu ticket and verified Resident 33 did not receive mashed potatoes.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's garbage and refuse was properly disposed of in three of seven garbage dumpsters. * Three garbage dumpsters were observed with the lids partially propped open by the cardboard boxes and black trash bags, preventing the lids from closing. This failure had the potential to harbor pests and rodents and cause unsafe sanitary conditions.Findings: Review of the facility's P&P titled Garbage and Rubbish Disposal dated 2020 showed garbage and rubbish will be disposed of to ensure a clean and sanitary kitchen that does not encourage insects or rodents. All outside dumpsters will be maintained in clean and sanitary condition. All garbage or rubbish is to be put into waste containers which are emptied as often as necessary to prevent overfilling. This will assist in the prevention of odors, pests, and possible contamination. All containers will be provided with tight-fitting lids or covers and will be leak proof and waterproof. All garbage and rubbish containing food waste are covered when not in immediate use so as to be inaccessible to vermin. Outdoor trash receptacles will be kept covered and the surrounding area kept free of litter. According to the 2022 FDA Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 4/12/26 at 1328 hours, an observation and concurrent interview was conducted with the Plant Operations Director. Three of seven garbage dumpsters were observed with the lids partially propped open by cardboard boxes and black trash bags preventing the lids from fully closing. The Plant Operations Director verified the findings and stated the dumpster lids should be completely always closed for safety and infection control purposes.