STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Rancho Mirage	72-201 Country Club Drive Rancho Mirage, CA 92270

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, and record review, the facility failed to ensure medications were administered in accordance with professional standards of practice for one of five residents observed for medication administration (Resident 17) when the staff turned on the nebulizer machine (a device that turns the liquid medicine into a mist which is then inhaled through a mouthpiece or a mask) before the resident placed the facemask over nose and mouth. This failure had the potential to result in the resident receiving less than the prescribed amount of medication, leading to ineffective drug therapy and a medication error due to inadequate medication administration. Findings: On April 21, 2025, at 9:01 a.m., during a medication administration observation with Licensed Vocational Nurse (LVN 1), LVN 1 was observed administering sodium chloride 3% inhalation solution (medication used in a nebulizer to help loosen mucus in the lungs, making it easier to clear from the lungs) to Resident 17 via nebulizer. It was observed LVN 1 added the inhalation solution into the nebulizer cup. LVN 1 then walked over to the nebulizer machine, which was located behind the resident's recliner, where the resident was seated, and turned on the machine. Mist began to be released immediately after the machine was turned on. LVN 1 then handed the face mask to Resident 17 from behind the recliner. Resident 17 was observed applying the face mask while mist was already being emitted from the nebulizer. A review of Resident 17's medical record titled Admission Record, indicated Resident 17 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD, lung disease causing difficulty breathing) with acute exacerbation (sudden worsening of the existing COPD symptoms with increased difficulty breathing, increased mucus production and coughing), pneumonia (lung infection), chronic respiratory failure with hypoxia (chronic lung condition with deficiency of oxygen). A review of Resident 17's medical record indicated there was a physician order on April 9, 2025, for Sodium Chloride Inhalation Solution 3%, with the direction to inhale 1 inhalation solution via nebulizer two times a day for COPD. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 21, 2025, at 3:20 p.m., during an interview with LVN 1, LVN 1 stated due to limited space and clutter around the resident's recliner, he turned on the nebulizer machine first and handed the facemask from behind the recliner to the resident as quickly as possible. LVN 1 confirmed the mist was already being released from the mask after turning on the machine, before the resident had secured the mask. LVN 1 stated he should have observed the resident properly place the facemask over the nose and mouth before turning on the nebulizer machine. LVN 1 acknowledged some medication might have dispersed into the room and the resident might not have received the full dose of medication. On April 24, 2025, at 2:45 p.m., during an interview with the Director of Nursing (DON), the DON stated the staff should have first observed the resident properly apply the face mask before turning on the nebulizer machine. The DON acknowledged there was a likelihood some medication was released into the airs within the resident's room and the resident might have inhaled less than the prescribed dose. The facility's policy and procedure titled, Administering Medications through a Small Volume (Handheld) Nebulizer, revised, October 2010, was reviewed, and it indicated: .Dispense medication into nebulizer cup . Turn on the nebulizer and check the outflow port for visible mist .Ask the resident to hold the mouthpiece gently between his/her lips (or apply face mask) . The National Institutes of Health (NIH, the United States' primary biomedical and public health research agency) publication titled, How to use a nebulizer, dated October 2021 indicated: .Put the prescribed amount of medicine into the nebulizer cup. Place the mouthpiece in your mouth and close your lips around it to form a tight seal. If uses a mask, make sure it fits snugly against the face and covers the nose and mouth. Turn on the nebulizer machine. You should see a light mist coming from the back of the tube opposite the mouthpiece or from the mask .

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51080 Based on observation, interview, and record review, the facility failed to ensure the tubing, feeding bottle, and water bag were labeled and dated for one of two residents (Resident 238) who receive enteral feeding (nutrition provided through a tube inserted into the stomach). This failure had the potential to cause food borne illness to Resident 238. Findings: On April 21, 2025, at 9:24 a.m., Resident 238 was observed receiving Jevity 1.2 CAL tube feeding nutrition and water through an electronic pump delivery system (e-pump), while sitting up in bed. The Jevity bottle, water bag and tubing were observed not labeled and dated. On April 21, 2025, at 9:36 a.m., in an concurrent observation and interview, Licensed Vocational Nurse (LVN) 2 confirmed the Jevity bottle, water bag and tubing were not labeled and dated. She stated these should have been labeled with date, time and the resident's name. On April 24, 2025, at 9:25 a.m. an interview with the Director of Nursing (DON) was conducted. The DON stated that the tubing, tube feed bottles, and water bag should be labeled with resident's name, orders, date and time it was opened. Resident 238's record was reviewed. Resident 238 was admitted to the facility on [DATE], with diagnoses which included dysphasia (condition that affects your ability to produce and understand spoken language), encephalopathy (a disease process that alters brain function) and cervical spine fracture (broken neck). A review of Resident 238's physician orders indicated .one time a day Jevity 1.2 60ml(milliliters-unit of measure)/hr for 10 hours Flush 20ml/hr for 10 hours, off at 1800 (6:00 pm) and on at 0400 .Change G-Tube Enteral Feeding Bag and Tubing every day . A review of (name of brand) Jevity 1.2 Cal product information, dated 7/22/2024, indicated, .consume within 24 hours . A review of Lippincott procedures, dated 2022, titled, Initiating Enteral Nutrition, indicated, .Label the container and administration set with the date and time it was first hung .

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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 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** 50610 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were provided to meet the needs of the residents when three medications with holding parameters were not administered in accordance with the physician's orders for one resident (Resident 14). This failure had the potential to significantly lower the blood pressure to cause dizziness, confusion, fainting and a fall. Findings: On April 24, 2025, a review of Resident 14's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included hypertension (HTN - high blood pressure) and atrial fibrillation (AFib - irregular heartbeat). A review of Resident 14's medical record indicated there were physician's orders for the following medications: - Benazepril (blood pressure medication) 5 mg (milligram, unit of measurement) with the direction to give 1 tablet by mouth at bedtime every 2 days for HTN, and hold for SBP (systolic blood pressure - the top number in blood pressure reading which measures how hard the heart pumps blood into arteries) less than 110 (mmHg, milliliter of mercury - unit of blood pressure measurement), dated March 21, 2025; - Terazosin (blood pressure medication) 5 mg with the direction to give 1 capsule by mouth at bedtime for HTN, and hold for SBP less than 110, dated March 21, 2025; and - Amiodarone (medication for irregular heart rhythm) 400 mg with the direction to give 1 tablet by mouth every 12 hours for AFib, hold for SBP less than 110 and/or HR (heart rate) less than 60. A review of Resident 14's Medication Administration Record (MAR), for March 2025 and April 2025, indicated Benazepril, Terazosin, and Amiodarone were administered to Resident 14 when the SBP was below 110 on the following dates and times: For Benazepril 5 mg: - March 23, 2025, at 2100 (9 p.m.), SBP 103; - March 25, 2025, at 2100 (9 p.m.), SBP 109; and - April 6, 2025, at 2100 (9 p.m.), SBP 104. For Terazosin 5 mg: - March 23, 2025, at 2100 (9 p.m.), SBP 103; (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- March 25, 2025, at 2100 (9 p.m.), SBP 109; - April 9, 2025, at 2100 (9 p.m.), SBP 96; and - April 13, 2025, at 2100 (9 p.m.), SBP 106. For Amiodarone 400 mg: - March 26, 2025, at 2100 (9 p.m.), SBP 93; - April 3, 2025, at 0900 (9 a.m.), SBP 108; - April 4, 2025, at 0900 (9 a.m.), SBP 105; - April 6, 2025, at 2100 (9 p.m.), SBP 104; - April 9, 2025, at 2100 (9 p.m.), SBP 96; and - April 13, 2025, at 2100 (9 p.m.), SBP 106. On April 24, 2025, at 2:45 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON verified the medications were documented as administered on the MAR for March 2025 and April 2025, despite the physician's order to hold the dose if the resident's SBP was below 110 mmHg. The DON acknowledged the physician's orders were not followed, and doses should have been held when the resident's SBP was below 110 mmHg. On April 24, 2025, at 3:15 p.m., during a concurrent interview with the facility's Consultant Pharmacist (CP), the CP stated he had not reviewed these medications since they were ordered after his most recent medication regimen review, completed on March 16, 2025. The CP stated if he had identified the holding parameters were not being followed for the blood pressure (BP) medications, he would have recommended for the physician to review the BP readings. The CP further stated he would have advised adjusting the medications or dosages as necessary to ensure safe administration. A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated: .Medications are administered in accordance with prescriber orders .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, and record review, the facility failed to ensure residents were free from unnecessary medications for one of five residents (Resident 14) when two medications from the same therapeutic (drug) class, proton pump inhibitors (PPI - a class of drug that reduce the amount of acid made by the stomach), were ordered and administered for the same indication. This deficient practice had the potential for unnecessary duplicate therapy or additive medication adverse effects including bone fractures and gastrointestinal (stomach and intestines) infections. Findings: On April 24, 2025, a review of Resident 14's Admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included gastroesophageal reflux disease (GERD - condition in which the stomach acid and contents flow back up into the esophagus and causes heartburn). A review of Resident 14's medical record indicated there was a physician orders for the following medications: - Pantoprazole (medication called proton pump inhibitor, PPI) 40 mg (milligram, unit of measurement), give 1 tablet by mouth in the morning for GERD, dated March 21, 2025; and - Omeprazole 20 mg (medication called PPI), give 1 tablet by mouth at bedtime for GERD, dated March 21, 2025. A review of Resident 14's Medication Administration Record (MAR), for March 2025 and April 2025 indicated both Pantoprazole 40mg and Omeprazole 20mg were administered daily from March 22 through April 23, 2025, with exception of April 8 and April 10, when Omeprazole 20 mg was not administered due to unavailability, as documented on the MAR with chart code 11 (med not available). There was no documented clinical rationale to justify the use of two different proton pump inhibitors, Pantoprazole 40mg in the morning and Omeprazole 20mg at bedtime, for the management of GERD. On April 24, 2025, at 2:45 p.m., during a concurrent interview and record review with the Director of Nursing (DON), the DON verified both Pantoprazole and Omeprazole were documented on the MAR as administered daily. The DON acknowledged the medications are from the same therapeutic class and have similar mechanisms of action (how the drug works to produce a desired effect in the body). (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 24, 2025, at 3:15 p.m., during a telephone interview with the facility's Consultant Pharmacist (CP), the CP stated he had not reviewed these medications since they were ordered after his most recent medication regimen review, completed on March 16, 2025. The CP added he would have questioned the duplicate PPI medication use and would have asked for clinical justification. The CP also stated if there was no documented clinical justification, he would have recommended the physician to discontinue one of the PPI medications and, if clinically indicated, adjust the dosing regimen of the remaining PPI to be administered twice daily. The CP further stated there is no benefit in administering two different PPI medications, as they belong to the same therapeutic class and have similar mechanism of action. The facility's policy and procedure titled, Administering Medications, revised, April 2019, was reviewed and it indicated: .If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident .the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns . A review of Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Pantoprazole tablets, revised January 2025, retrieved from DailyMed (internet database operated by the U.S. National Library of Medicine providing labeling for prescription and nonprescription drugs), indicated: .Protonix (brand name for pantoprazole) is a proton pump inhibitor indicated for short-term treatment of GERD .Dosage for GERD .40 mg once daily for up to 8 weeks .suppresses the final step in gastric (stomach) acid production .Bone Fracture: Long-term and multiple daily dose PPI therapy may be associated with an increased risk for osteoporosis-related (a disease that weakens the bones) fractures of the hip, wrist or spine . A review of Prescribing Information for Omeprazole tablets, revised September 2012, retrieved from DailyMed, indicated: .Prilosec (brand name for omeprazole) is a proton pump inhibitor indicated for treatment of GERD .Dosage for GERD: 20mg once daily for 4 to 8 week .suppresses gastric acid secretion .PPI therapy may be associated with increased risk of Clostridium difficile associated diarrhea .Bone fracture: Long-term and multiple-daily dose PPI therapy may be associated with an increased risk for osteoporosis-related fractures of the hip, wrist or spine . A review of the National Institute of Health (NIH)'s National Library of Medicine (NLM, a nationally recognized source of medical information), titled Interchangeable Use of Proton Pump Inhibitors Based on Relative Potency, dated December 16, 2019, indicated: .consensus conferences have suggested that PPIs are more similar than different .The World Health Organization Collaborating Centre for Drug Statistics Methodology proposed that 20 mg omeprazole .40 mg pantoprazole .were equivalent for the treatment of GERD .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50610 Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications and devices in accordance with the facility's policies and procedures and/or manufacturer's instructions when: 1. One discontinued medication was stored in the Red Medication Cart with other active medications available for use; 2. A total of three expired medications and devices were stored in the Red Medication Cart, IV Cart (a cart used to store medications and supplies needed for intravenous medications given through a vein), Treatment Cart (a cart used to store medication and supplies needed for wounds treatment), and Medication Room; and 3. A total of three medications with incorrect expiration dates were stored in the IV Cart and refrigerator in the Medication Room. These failures had the potential for residents to receive discontinued, expired, or ineffective medications, leading to medication errors and compromised treatment outcomes. Findings: 1. On April 21, 2025, at 3:35 p.m., during an inspection of Red Medication cart in the Red Hall with Licensed Vocational Nurse (LVN 3), a blister card containing Calcium Acetate (supplement) 667 mg (milligram, unit of measurement) capsules were observed stored in active stocks, despite the order being discontinued. The label on the blister card indicated it was prescribed for Resident 24 with the direction to give one capsule by mouth with meals for supplement. The pharmacy fill date (the date the pharmacy dispensed the medication) on the label indicated 03/22/2025 (March 22, 2025) and four capsules remained in the blister card. During a concurrent interview and record review with LVN 3, LVN 3 verified the order for calcium acetate 667 mg capsules was discontinued on April 5, 2025. LVN 3 further stated the order had been changed to calcium acetate 667 mg tablets, with the direction to give three tablets before meals for supplement. Two blister cards containing the tablets for the active order were observed stored in the same medication cart. LVN 3 acknowledged the discontinued medication should not have been stored in the medication cart and should have been removed from the medication cart and properly disposed of in the pharmaceutical waste bin located in the medication room. The facility's policy and procedure (P&P) titled Discontinued Medications, revised November 2022, was reviewed, and indicated: .Staff shall destroy discontinued medications .Discontinued medications are destroyed .with facility policy and state regulations . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. On April 21, 2025, at 4:13 p.m., during an inspection of Red Medication cart in the Red Hall with LVN 3, an unused 3-mL Basaglar KwikPen (Insulin Glargine - a long-acting insulin used to prevent high blood sugar) 100 units/mL (units per milliliter, unit of measurement) for injection was observed stored at a room temperature with the open date written for 3/7/25 (March 7, 2025). The label on the insulin pen indicated it was prescribed for Resident 24 with the direction to Inject 6 units subcutaneously (Sub-Q - injection given in the fatty tissue under the skin) every night at bedtime for DM (Diabetes Mellitus - a condition where the body has trouble regulating blood sugar levels). During a concurrent interview with LVN 3, LVN 3 verified the insulin pen was expired. LVN 3 stated it should not have been stored in the medication cart beyond 28 days and should have been removed and properly disposed of in the pharmaceutical waste bin located in the medication room. The facility's P&P titled, Medication Labeling and Storage, revised February 2023, was reviewed, and indicated: .multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date . A review of the manufacturer's Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for BASAGLAR KwikPen, revised November 2023, indicated: .Storage and Handling .Not In-Use (Unopened) Room Temperature .28 days . 2b. On April 22, 2025, at 9:15 a.m., during an inspection of IV cart with the Assistant Director of Nursing (ADON), a total of six syringes of expired Heparin Lock Flush Solutions (solution to keep the IV line open by preventing blood clots from forming, and help fluids or medications keep flowing freely), 50 USP units/5mL (USP units per milliliter, unit of measurement) in 0.9% sodium chloride were identified. The manufacturer's expiration dates on the syringes indicated June 2024. During a concurrent interview with the ADON, the ADON confirmed the Heparin lock flush syringes were expired. The ADON stated it should not have been stored in the IV cart and should have been removed and properly disposed of in the pharmaceutical waste bin located in the medication room. 2c. On April 22, 2025, at 10:08 a.m., during an inspection of the Treatment cart conducted with LVN 4, a bottle of Adapt Stoma Powder (drug used to absorb moisture from broken or irritated skin around a stoma, a surgically created opening on the abdomen) was observed stored with the manufacturer's expiration date of June 2024. During a concurrent interview with LVN 4, LVN 4 confirmed the medication was expired and acknowledged the expired treatment medication should not have been stored in the treatment cart and should have been removed and properly disposed of in the pharmaceutical waste bin located in the medication room. 2d. On April 22, 2025, at 3: 26 p.m., during an inspection of the medication room conducted with the Director of Nursing (DON), additional expired Heparin lock flush syringes were identified in the bottom cabinet located under the sink. One partial and one full box of Heparin lock flush syringes had the manufacturer's expiration date of June 2024. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with DON, the DON confirmed the Heparin lock flush syringes were expired. The DON stated the expired syringes should not have been stored in the medication cabinets and should have been removed and placed in the designated disposal cabinet for medications located in the same medication room. The facility's P&P titled Medication Labeling and Storage, revised February 2023, was reviewed, and indicated: .If the facility has .outdated .medications ., the dispensing pharmacy is contacted for instructions regarding returning or destroying these items . The facility's P&P titled Discarding and Destroying Medications, revised April 2019, was reviewed, and indicated: .Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals .Staff shall contact the provider pharmacy if they are unsure of proper disposal methods for medications . 3a. On April 22, 2025, at 9:28 a.m., during an inspection of the IV cart conducted with ADON, the following IV diluent bags (small IV fluid bags used to dilute medications) for Resident 24 were observed stored out-of-overwrap (outside of the manufacturer's overwrap) without a documented beyond-use date (BUD - the date after which a medication that has been opened, mixed, or prepared should no longer be used, as its safety and effectiveness may no longer be guaranteed): - Nine bags of [NAME] 0.9% Sodium Chloride (NS - normal saline) 100 mL (milliliter, unit of measurement) sterile single-dose VIAFLEX (type of container) containers were observed for Resident 24 with the direction to use as directed with daptomycin (drug used to treat infection). The label indicated the pharmacy fill date of 03/28/2025 (March 28, 2025), and the expiration date of 4/26 (April 2026), matching the manufacturer's expiration date; and - Six bags of [NAME] NS 100 mL sterile single-dose VIAFLEX containers were observed for Resident 24 with the direction to use as directed with ceftriaxone (drug used to treat infection). The label indicated the pharmacy fill date of 03/28/2025 (March 28, 2025), and the expiration date of 4/26 (April 2026), matching the manufacturer's expiration date. On April 24, 2025, at 3:34 p.m., a telephone interview was conducted with Pharmacist 1. The Pharmacist 1 stated the pharmacy was not aware of this storage limit until the question was raised. According to a reference from the American Society of Health-System Pharmacists (ASHP - a nationally recognized organization that provides evidence-based guidance on safe medication use and storage practices in healthcare setting)'s publication titled, Applying Stability Data in Sterile Compounding, in the 7th edition of Extended Stability for Parenteral Drugs, dated on September 29, 2022, indicated: .Table 7: Manufacturer Storage of Commercial IV Solution Containers after Removal from Protective Overwrap . Viaflex containers .Volume ? 100 mL .Maximum Storage Time (Room Temperature) 30 d (days) . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3b. On April 22, 2025, at 9:59 a.m., during an inspection of the Medication Room conducted with the ADON, a total of eight compounded Ceftriaxone bags for IV infusion were observed stored in the medication refrigerator with the expiration date of 04/21/26 (April 21, 2026) which was one year from the pharmacy's fill date of 04/21/2025 (April 21, 2025). The labels on the bags indicated the medications were for Resident 24, with the direction to administer ceftriaxone 1 gm (gram - unit of measurement) (50ml) intravenously over 30 minutes once daily via PICC (peripherally inserted central catheter - a type of long, thin tube placed in a large vein in the arm to give medications or fluids over a long period of time) line using gravity tubing (a way to give fluids or medicine through an IV by using gravity) as directed at bedtime for bone infection. During a concurrent interview with ADON, the ADON stated the compounded IV medications were provided by a compounding pharmacy, contracted with the dispensing pharmacy to supply IV medications to the facility. On April 24, 2025, at 3 p.m., during a telephone interview with Pharmacist 2, the Pharmacist 2 stated the expiration date on the label was incorrect and the BUD for the compounded ceftriaxone IV bags should have been 10 days. The Pharmacist 2 stated the compounding pharmacy follows the USP <797> (the United States Pharmacopeia - a set of standards issued by the USP that provides guidelines to ensure the safe preparation, handling, and storage of sterile compounded medications) BUD limits for Category 2 CSPs (compounded sterile preparations - made in sterile condition) with the maximum storage of 10 days at refrigerator. A review of the undated reference titled, USP-797, provided by Pharmacist 2, indicated: .Table 13. BUD Limits for Category 2 CSPs: Compounding method: aseptically processed CSPs, no sterility testing performed and passed, prepared from only sterile starting components: 10 days at refrigerator . The facility's P&P titled, Medication Labeling and Storage, revised February 2023, was reviewed, and indicated: .For medications that are prepared or compounded for intravenous infusion, the label contains . date after which the mixture cannot be used . 3c. On April 22, 2025, at 3: 26 p.m., during an inspection of refrigerator in the medication room with the DON, a refrigerated Emergency Kit (E-kit, a sealed container with various medications for use in emergencies) was observed with the label on the outside of the E-kit container indicating an expiration date of 6/26 (June 2026). One of the medications stored in the E-kit was Cathflo Activase (medication used to break down blood clots and help unblock IV tubes, inserted to vein) 2 mg with the manufacturer's expiration date of October 2025. During a concurrent interview with the DON, the DON confirmed the expiration date of the Cathflo and stated the earliest expiration date of the medications stored in the E-kit should be indicated on the outside of the E-kit container to ensure no resident receives expired medication. On April 24, 2026, at 3:15 p.m., during a telephone interview with the facility's Consultant Pharmacist (CP), the CP stated he had checked the facility's E-kit during his visit. The CP also confirmed the earliest expiration date should have been indicated on the outside of E-kit container. On April 24, 2025, at 3:34 p.m., during a telephone interview with Pharmacist 1, Pharmacist 1 confirmed the E-kit had been provided by his pharmacy and acknowledged the earliest expiration date should have been written on the outside of the E-kit. (continued on next page)

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	555775	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bayshire Rancho Mirage	72-201 Country Club Drive Rancho Mirage, CA 92270

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's P&P titled, Emergency Medications, dated April 2021, was reviewed and indicated: .The consultant pharmacist shall inspect the emergency medication kits monthly and record the findings on the record maintained with each kit . The facility's P&P titled, Medication Labeling and Storage, revised February 2023, was reviewed, and indicated: .labeling of medications .dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices .The medication label includes, at a minimum . expiration date .If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items .

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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. 44173 Based on observation, interview, and record review, the facility failed to ensure the [NAME] followed the recipe for preparing pureed bread for dinner on April 21, 2025. This failure had the potential to compromise the nutritional needs for one resident (Resident 138) reviewed for pureed diet. Findings: On April 21, 2025, at 3:54 p.m., the Cook, with the presence of the Dietary Manager (DM), was observed to prepare pureed bread for a resident who was on pureed diet (Resident 138). The [NAME] had the recipe for pureed bread in front of her as she read the directions. The [NAME] was observed conducting the following: a. Put five (5) slices of white bread, cut in small pieces, in the blender, and added three quarters (3/4) cup of regular milk and turned on the blender. b. Turned off the blender, used a wooden spoon to stir the contents in the blender which was of thick consistency. c. Added three more cups of regular milk and turned on the blender. d. Poured the contents of the blender in a metal container and added two spoonsful of thickener to the mixture and stirred it with the wooden spoon. The [NAME] used a disposable spoon to measure the thickener instead of using the appropriate measuring spoon. The pureed bread was runny and with a watery consistency. The [NAME] stated she followed the recipe for pureed bread and it was the right consistency. The DM who was present during the observation was asked to check the pureed bread made by the Cook. The DM used the wooden spoon to stir the pureed bread and stated it had the right consistency for pureed bread. The Registered Dietician (RD) was called to verify the consistency of the pureed bread. On April 21, 2025, at 4:08 p.m., the RD walked in the kitchen to verify the consistency of the pureed bread made by the Cook. The RD stated the pureed bread made by the [NAME] was watery and did not have the right consistency for pureed diet. She stated pureed diet should have a pudding-like consistency which is cohesive with no lumps. She stated when you scoop the pureed food with a spoon, the puree should hold its shape and form. She stated when you tilt the spoon, the puree will slide off easily. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 24, 2025, at 9:03 a.m., during an interview with the RD, she stated the [NAME] did not follow the recipe for making pureed bread. She stated the [NAME] should have followed the recipe for pureed diet to get the right consistency and thickness. During review of the facility document titled, PUREED Bread Products, revised October 06, 2021, indicated, . Yields .5 (five servings) .Ingredients .Bread product .5 Each .Broth*, Milk*, or Juice* .3/4 cup .Thickener**, food .1 1/2 (one and a half) Tsp (teaspoon) .Directions .Remove portions required form the regular prepared recipe and place in food processor. Gradually add liquid to bread while processing and process until smooth. All liquid may not be required .Ensure mixture achieves smooth, lump free and extremely thick consistency . A review of the facility policy and procedure titled, STANDARDIZED RECIPES, revised August 31, 2018, indicated, .Standardized recipes will be used .Recipes note how to prepare the food items in order to preserve vitamins, taste, and appearance . A review of the facility policy and procedure titled, Mechanically Altered Diet Explanation (3 Levels), revised May 6, 2019, indicated, .Puree all foods to the consistency of smooth, moist mashed potatoes or pudding-like consistency .

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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 - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices were followed in accordance with professional standards of practice when: 1. Four half (,d+[DATE]) size sheet steam drip metal pans and three eight quarts (8-qts - a unit of measurement) pitchers were stored wet; 2. One cup of undated cut fruits and one five pound (5-lb) tub low fat cottage cheese with an expiration date of [DATE], were found stored in the satellite kitchen refrigerator; and 3. One undated open bottle of reduced fat ultra filtered milk was found stored in the resident's refrigerator. These failures had the potential to cause food-borne illnesses (stomach illness resulting from ingestion of contaminated food) in a medically vulnerable population who received food prepared in the kitchen. Findings: 1. On [DATE], at 9:01 a.m., an initial tour of the main kitchen was conducted with the Dietary Manager (DM). Four ,d+[DATE] size sheet steam drip metal pans and three 8-qts pitchers were observed stored wet. During a concurrent interview with the DM, she stated the ,d+[DATE] size sheet steam drip metal pans and the 8-qts pitchers should not be stored wet. On [DATE], at 9:03 a.m., during an interview with the Registered Dietician (RD), the RD stated all dishes should be air-dried after every wash. She also stated the dishes should not be stored or stacked wet. She stated moist or wet dish can harbor bacteria that could result in food-borne illnesses. The facility policy and procedure titled, DISHWASHING PROCEDURE, revised [DATE], indicated, .Air dry dishes by racking or putting on single trays lined with mesh . A review of Food and Drug Administration (FDA - agency responsible for protecting public health by ensuring the safety of the food supply) Food Code 2022, Section ,d+[DATE].11, titled, Equipment and Utensils, Air-Drying Required, indicated, .After cleaning and SANITIZING, EQUIPMENT and UTENSILS .Shall be air-dried . 2. On [DATE], at 9:51 a.m., an initial tour of the satellite kitchen tour was conducted with the Dietary Aide (DA). One undated cup of cut fruits and one 5-lb tub of low-fat cottage cheese with an expiration date of [DATE], were found stored in the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with the DA, she stated the cup of fresh fruits should have a date and the low-fat cottage cheese should have been discarded on [DATE]. On [DATE], at 9:03 a.m., during an interview with the RD, she stated the cut fruits were prepared in the main kitchen and delivered to the satellite kitchen for storage in the refrigerator. She stated the cut fruits should have a date when they were prepared before they were stored in the refrigerator. She stated the date will help the staff ensure the food is fresh and safe for resident consumption. The RD also stated, the kitchen staff should check all the food in the refrigerator. She stated the kitchen staff should check for expiration dates every day. She stated there should be no expired food in the refrigerator. 3. On [DATE], at 10:11 a.m., an inspection of the resident's refrigerator located in the dining area was conducted with the DA. One undated open bottle of reduced fat ultra filtered milk labeled with a resident's name was found in the refrigerator. During a concurrent interview with the DA, she stated the staff should put a date on the resident's food when they put them in the refrigerator. She stated the resident's reduced fat ultra filtered milk should have been dated when it was opened. On [DATE], at 1:46 p.m., the Certified Nurse Assistant (CNA) was interviewed. The CNA stated the staff should label resident's food with the room number, resident's name and the date it was received before storing them in the resident's refrigerator. On [DATE], at 9:03 a.m., during an interview with the RD, she stated all open food containers should have an open date. The RD stated the staff should label all food brought from home with an open date or the date the food was brought in the facility. She stated resident's food should be good for three to five days from the open date. The facility policy and procedure titled, FOOD STORAGE, revised [DATE], indicated, .Any expired or outdated food products should be discarded .All food products should be inspected for safety and quality and should be dated upon receipt, when open, and when prepared .Remember to cover, label and date .