

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 07/18/2026  
Form Approved OMB  
No. 0938-0391

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>555900                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                                  | (X3) DATE SURVEY<br>COMPLETED<br><br>01/30/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Veterans Home of California - Fresno                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2811 W Cesar Chavez Blvd<br>Fresno, CA 93706 |                                                 |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                           |                                                 |
| (X4) ID PREFIX TAG                                                                                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                           |                                                 |
| F 0755<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Many                        | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on interview and record review, the facility failed to provide pharmaceutical services to meet the needs of residents when the facility did not employ or obtain the services of a licensed pharmacist. This failure resulted in no pharmacist oversight for required pharmacy services and had the potential risk to affect all residents receiving medications. Findings: During an interview with Supervising Registered Nurse (SRN) 2 on 1/29/26 at 9:32 am, SRN 2 stated there was no pharmacist reviewing medications monthly for residents since October 2025. During an interview with Skilled Nursing Facility Administrator (SNF Admin) on 1/29/26 at 10:34 am, SNF Admin stated the facility did not have a pharmacist in November 2025, December 2025, and January 2026. During a review of the facility's policy and procedure titled, Pharmaceutical Services dated 9/25/25, indicated, .Pharmaceutical Services will include, but not limited to, the following: Providing consultative and other services furnished by pharmacists, which assist in the development, coordination, supervision, and review of the pharmaceutical services within the SNF .</p> |                                                                                           |                                                 |

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| <p>F 0756</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Many</p>                | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to ensure a licensed pharmacist conducted monthly drug regimen reviews (DRR) when four sampled residents (Residents 3, 7, 21, and 50) did not have evidence of drug regimen reviews since October 2025. This failure resulted in the potential for unidentified medication-related irregularities due to the absence of required drug regimen reviews. Findings: During a review of Resident 3's admission Face Sheet Record, undated, indicated Resident 3 was admitted to the facility with diagnoses of vascular dementia (a form of memory loss due to impaired supply of blood to the brain), hyperlipidemia (high level of fats in the blood), and diabetes mellitus (high blood sugar). During a review of Resident 7's admission Face Sheet Record, undated, indicated Resident 7 was admitted to the facility with diagnoses of dementia (memory loss), hypertension (high blood pressure), and hyperlipidemia. During a review of Resident 21's admission Face Sheet Record, dated 12/26/25, indicated Resident 21 was admitted to the facility with pain in the left knee, non-rheumatic aortic valve stenosis (heart condition where the aortic valve narrows due to calcium buildup or structural abnormalities, restricting blood flow). During a review of Resident 50's admission Face Sheet Record, undated, indicated Resident 50 was admitted to the facility with diagnoses of dementia, diabetes mellitus, and hypertension. During a concurrent interview and record review on 1/29/26 at 9:14 am with Supervising Registered Nurse (SRN) 4, Resident 21's chart was reviewed. Resident 21 did not have a DRR since his admission on [DATE]. SRN 4 stated the facility had not had a pharmacist since October 2025, and there was no DRR done for Resident 21. During a concurrent interview and record review on 1/29/26 at 9:32 am with SRN 2, the most recent DRR was reviewed. SRN 2 stated the last DRR completed for Residents 3, 7, and 50 was on 10/24/25 by the former pharmacist. SRN 2 stated there was no pharmacist completing the DRR since October 2025. SRN 2 stated there was no developed structure to complete DRR when the pharmacist stopped reviewing the medications. During an interview on 1/29/26 at 11:45 am with Quality Registered Nurse (QRN) 1, QRN 1 stated there were no pharmacy reviews of the residents' medications for a few months because there was no pharmacist on staff to complete them. During an interview with Skilled Nursing Facility Administrator (SNF Admin) on 1/29/26 at 10:34 am, SNF Admin stated the facility did not have a pharmacist in November 2025, December 2025, and January 2026. SNF Admin stated pharmacist reports were not completed during this time. During a review of the facility's policy and procedure titled, Drug Regimen Review, dated 4/1/25, indicated, A pharmacist will review the drug regimen of each Resident at least monthly and prepare appropriate reports. The goal is to promote positive outcomes and to minimize adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or any other irregularities.</p> |                                                                                           |                                                 |

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| <p>F 0761</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to safely store medications when two containers of discarded medications, designated for disposal, was found in Building 1A's soiled utility room and one container of discarded medications, designated for disposal, was found in Building 5A's soiled utility room and were accessible to unlicensed personnel. These failures had the potential for unauthorized access to medications. Findings: During a concurrent observation and interview on [DATE] at 2:08 pm with Registered Nurse (RN) 5 in the medication room in Building 1 A, a blue waste container with a white top was on the counter. RN 5 stated the container held non-controlled resident medications that were no longer in use and were to be disposed of. RN 5 stated the medications in the container were kept in its original pill form and once the container was full, it would be placed in a bigger bin in the soiled utility room, which was located across the hall from the medication room, for pickup and disposal. During a concurrent observation and interview on [DATE] at 2:30 pm with Quality Registered Nurse (QRN) 1, bins labeled for pharmaceutical waste were found in the unlocked soiled utility room. QRN 1 stated the medications were kept in that room and the housekeepers would pick up these disposed medications, along with the other trash bins, to transport them to the facility's building. From that building, an outside contracted company would pick up the medications to destroy. During a concurrent observation and interview on [DATE] at 2:47 pm with Supervising Registered Nurse (SRN) 3 in the Building 5A medication room, a blue container and a black container, with lids open, were sitting on the counter. SRN 3 stated the blue container was for discontinued and expired uncontrolled medications in pill and tablet form. SRN 3 stated the black container was for discontinued and expired uncontrolled medications like inhalers. SRN 3 stated the nurses used plastic bags to bag up the blue and black containers located in the medication room and walked them across the hallway to the soiled utility room to be placed in designated bins. SRN 3 stated the nurses put the black containers into the designated bin in the soiled utility room labeled RCRA [Resource and Conservation Recovery Act- a United States law enacted to govern the disposal of solid waste and hazardous waste] ONLY. SRN 3 stated the nurses put the blue containers into the designated bin in the soiled utility room labeled NON HAZARDOUS PHARMACEUTICAL. SRN 3 stated Environmental Services (EVS) staff picked up the blue and black containers of discontinued and expired uncontrolled medications from the designated bins in the soiled utility room to be taken to another location where a contracted company came to pick them up to destroy them. During an observation on [DATE] at 3:13 pm in the Building 5A soiled utility room, one container of discarded medications was tied in a clear plastic bag in the bottom of a gray-colored bin labeled RCRA ONLY. During an interview on [DATE] at 3:15 pm with SRN 4, SRN 4 stated EVS picked up the bagged black and blue containers containing the discontinued and expired uncontrolled medications from the soiled utility room and took them to a back warehouse to be picked up by a contracted company for disposal. SRN 4 stated the warehouse was accessible by warehouse staff members, EVS staff members, security personnel and supervisors. During an interview on [DATE] at 3:25 pm with SRN 2, SRN 2 stated only licensed nurses and pharmacy techs have access to residents' medications. Unlicensed staff would be supervised by authorized staff if they needed access to the rooms where medications are located. During an interview on [DATE] at 4:04 pm with SRN 4, SRN 4 stated the authorized staff members who handled medications included all Licensed Vocational Nurses (LVN) and RN as well as pharmacy staff. SRN 4 stated all facility staff members have access to enter the hallway in Building 5A that leads to the soiled utility room. SRN 4 stated the soiled utility room was not locked, therefore any staff member could access the soiled utility room. SRN 4 stated the blue and black containers were kept in designated bins in the soiled utility room until removed by EVS staff for disposal. SRN 4 highlighted (continued on next page)</p> |                                                                                           |                                                 |

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| F 0761<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | the risk that staff could access discarded medications from these containers.During a review of the facility's policy and procedure (P&P) titled, Drug Storage dated [DATE], the P&P indicated, .Drugs and biologicals in the Skilled Nursing Facility (SNF) are stored in compliance with applicable State, Federal, and local laws and regulations.To ensure all drugs and biologicals in the SNF are stored in such a manner so as to maintain their security and integrity.Drug storage containers must not be.without secure closures.Drugs will be accessible only to authorized personnel designated in writing by the SNF.Discontinued drug and biological containers.will be stored in a separate location which will be identified solely for this purpose in the medication room.During a review of a list of classifications authorized to access medications dated [DATE], the list indicated that Licensed Vocational Nurses, Registered Nurses, Supervising registered Nurses, Supervising Nurse II, and Pharmacy Technician. |                                                                                           |                                                 |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Some</p>                | <p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility did not ensure an effective infection control and prevention program for three of 24 residents (Residents 10, 14, and 21), when nursing staff did not follow the use of PPE (personal protective equipment -specialized gear such as masks, gloves, gowns, and eye protection designed to protect healthcare workers from infectious materials and pathogens) for enhanced barrier precautions (EBP - an infection control strategy for nursing homes, requiring staff to wear gowns and gloves during high-contact resident care to reduce the spread of germs) when providing care to the residents.1. CNA 1 and LVN 1 did not wear a gown while providing care for Resident 102. CNA 2, RN 1, and SRN 1 did not wear a gown while providing care for Resident 143. CNA 3 did not wear a gown while providing care for Resident 21.This failure had the potential to place residents 10, 14, and 21 at risk for acquiring an infectious bacteria through cross contamination which could lead to illness or death.Findings:1.During an observation on 1/26/26 at 3:25 p.m. outside of Resident 10's room, there was a sign on the door indicating Enhanced Barrier Precautions. Resident 10 had an indwelling urinary catheter (a flexible tube inserted through the urethra into the bladder to continuously drain urine into an external collection bag). Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1 were inside the room assisting Resident 10 transfer from the bed to the wheelchair. CNA 1 moved his catheter bag from the bed to the wheelchair and moved Resident 10's blanket from his bed to the wheelchair. Both CNA 1 and LVN 1 did not have a gown when assisting Resident 10. During an interview on 1/28/26 at 11:14 a.m. with CNA 1, CNA 1 stated when a resident was on EBP, staff needed to wear gowns and gloves during patient care. CNA 1 stated tasks such as transferring the resident, moving a catheter bag would indicate the need to wear a gown. CNA 1 stated she should have worn a gown while providing care for Resident 10. CNA 1 stated the gown was necessary to avoid transferring of any germs to Resident 10.During an interview on 1/28/26 at 3:28 p.m. with LVN 1, LVN 1 stated Resident 10 was on EBP due to having a urinary catheter. LVN 1 stated she should have worn a gown and gloves while assisting Resident 10 to transfer from his bed to the wheelchair. LVN 1 stated a gown would protect Resident 10 from acquiring any possible bacteria that could lead to infection due to the urinary catheter. During a review of Resident 10's Care Plan (CP), dated 12/5/25, the CP indicated Resident 10 had an indwelling urinary catheter.2. During an observation on 1/27/26 at 9:31 a.m. near Resident 14's room, there was a sign on the door indicating EBP. Resident 14 was stating he was having difficulty breathing. Supervising Registered Nurse (SRN) 1, Registered Nurse (RN) 1, and CNA 2 were in Resident 14's room providing patient care. The staff checked Resident 14's vital signs. SRN 1 provided a breathing treatment to Resident 14. The staff were not wearing gowns during patient care for Resident 14. During an interview on 1/28/26 at 10:46 a.m. with RN 4, RN 4 stated any time a resident had an indwelling urinary catheter, staff should wear a gown and gloves during high contact activity with the resident. RN 4 stated providing a breathing treatment for Resident 14 would be considered high contact with the resident which would require wearing a gown. During a review of Resident 14's CP, dated 8/13/25, the CP indicated Resident 14 had an indwelling urinary catheter. 3. During a concurrent observation and interview on 1/27/26 at 10:03 a.m. with CNA 3, near Resident 21's room, there was a sign on the door indicating EBP. CNA 3 was in the room grooming Resident 21's hair, and moving linen in his room. CNA 3 stated she was grooming Resident 21's hair and changing his linen. CNA 3 did not have a gown on during patient care. During an interview on 1/28/26 at 3:28 p.m. with LVN 1, LVN 1 stated Resident 21 was on EBP due to having an indwelling urinary catheter. LVN 1 stated any patient care that required contact with the resident required staff to wear a gown such as grooming or changing linen. LVN 1 stated the gown was to prevent Resident 21 from acquiring a bacteria that could lead to infection due to his urinary catheter. LVN 1 stated CNA 3 should have placed a gown on when she was grooming Resident 21 and changing his linen. During a review of Resident 21's CP, dated 1/9/26, the CP indicated Resident 21 had an indwelling urinary</p> <p>(continued on next page)</p> |                                                                                           |                                                 |

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| F 0880<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Some                        | catheter.During an interview on 1/29/26 at 11:32 a.m. with the Infection Preventionist (IP), the IP stated EBP was implemented for any residents that had Multidrug - Resistant Organisms (MDRO -bacteria or other microorganisms that have developed resistance to at least three classes of commonly used antimicrobial drugs, making infections difficult to treat), indwelling devices, or wounds that required dressings. The IP stated prevention of infection was the rationale for PPE use. The IP stated wearing gowns and gloves for high contact activities such as dressing, transferring, providing hygiene was important to prevent cross-contamination of bacteria. The IP stated staff providing care to Residents 10, 14, and 21 all needed to wear gowns and gloves for the type of care being provided. During a review of the policy and procedure (P&P) titled Enhanced Barrier Precautions dated 12/30/25, the P&P indicated, .Enhanced Barrier Precautions: Infection control interventions requiring gown and glove use during high-contact resident care activities to reduce the spread of MDROs.High Contact Activities: These include dressing, bathing, transferring, providing hygiene, changing linens, assisting with toileting, caring for indwelling medical devices, and performing wound care.Medical Devices: Identify residents with indwelling medical devices. (e.g., central venous catheters, urinary catheters). Implement EBP for residents with indwelling medical devices, regardless of MDRO status, due to the risk of contracting an MDRO.Focus on the use of gown and gloves during high-contact resident care activities. |                                                                                           |                                                 |

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| <p>F 0628</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Provide the required documentation or notification related to the resident's needs, appeal rights, or<br/>bed-hold policies.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on<br/>interview and record review, the facility failed to ensure proper discharge notification and<br/>documentation were made for one of two closed record sampled residents when: The facility did not<br/>notify the State Long Term Care Ombudsman of Resident 113's discharge. The facility did not perform<br/>and document a discharge medication reconciliation (process of comparing pre-discharge medications<br/>and post-discharge medications) for Resident 113 upon discharge from the facility. These failures had<br/>the potential to adversely affect the continuity of care for Resident 113. Findings: 1. During a review of<br/>the Resident Demographics (Face Sheet), the Face Sheet indicated Resident 113 was admitted to the<br/>facility on [DATE] with diagnoses which included compression fracture (a bone in the spine<br/>collapsed or flatten due to pressure) and hypertension (high blood pressure). During a review of<br/>Resident 113 Physician Orders, dated 1/5/26, the Physician Orders indicated, May discharge to RCFE<br/>[Residential Care Facilities for the Elderly- non medical residential setting for elderly persons] due to<br/>goals met. Review of Resident 113's chart indicated there was no documentation that the ombudsman<br/>was notified of Resident 113's discharge. During an interview on 1/29/26 at 11:54 am with Quality<br/>Registered Nurse (QRN) 1, QRN 1 stated the ombudsman was not notified when residents were<br/>discharged from the facility to RCFE. During an interview on 1/29/26 at 4:18 pm with the Standards<br/>Compliance Coordinator (SCC), the SCC stated the facility did not send notification of Resident 113's<br/>discharge to the ombudsman. SCC also stated the facility did not have policies and procedures on<br/>ombudsman notification process. 2. During a review of the Resident Demographics (Face Sheet), the<br/>Face Sheet indicated Resident 113 was admitted to the facility on [DATE] with diagnoses which<br/>included compression fracture (a bone in the spine collapsed or flatten due to pressure) and<br/>hypertension (high blood pressure). During a review of Resident 113 Physician Orders, dated 1/5/26,<br/>the Physician Orders indicated, May discharge to RCFE [Residential Care Facilities for the Elderly-<br/>non medical residential setting for elderly persons] due to goals met. During a concurrent interview<br/>and record review on 1/29/26 at 10:09 am with Quality Registered Nurse (QRN) 1, QRN 1 stated that<br/>medication reconciliation was not performed and documented as part of the facility's discharge<br/>process when a resident was discharged to the RCFE. QRN1 confirmed that there were no physician<br/>orders for Resident 113's discharge medications in the resident's record. During an interview on<br/>1/29/26 at 4:48 pm with Nurse Educator (NRS ED) 2, NRS ED 2 stated upon discharge from the<br/>facility, the resident's current medications should be reconciled with the medications the resident will<br/>require at discharge. NRS ED 2 further stated the physician should document an order for the<br/>resident's discharge medication in the record. During an interview on 1/30/26 at 9:20 am with the<br/>Medical Director (MD Director), the MD Director stated that when a resident was discharged from the<br/>facility, the nurse should call the physician to ask about medication changes for the resident's<br/>discharge; however, a complete medication list was not usually reviewed during call. MD Director<br/>stated that the medication reconciliation and discharge medication list was not performed during<br/>discharge from the facility to RCFE. Review of Resident 113's chart indicated there was no<br/>documentation the medication reconciliation was conducted and no documentation of physician's<br/>orders for discharge medications for Resident 113's discharge from the facility. Requested a policy<br/>related to discharge medication reconciliation. A policy was not provided during survey.</p> |                                                                                           |                                                 |

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| F 0690<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections for one of 24 residents, when Resident 4's indwelling urinary catheter bag (a bag connected to a tube that drains urine from the resident's bladder) was observed on the floor. This failure had the potential to result in catheter-associated urinary tract infection (CAUTI) [an infection that can occur when germs enter the bladder through the tube]. Findings: During an observation on 1/28/26 at 11:11 am in Resident 4's room, Resident 4 was observed lying in bed with the urinary catheter drainage bag resting directly on the floor. During a concurrent observation and interview on 1/28/26 at 11:17 am with Registered Nurse (RN) 2, RN 2 confirmed that the catheter bag was on the floor, acknowledging it posed an infection risk. During an interview on 1/28/26 at 11:33 am with Infection Preventionist (IP) IP confirmed that the urinary catheter bag should not be on the floor. IP stated, It should be hanging above the floor. It should not be sitting on the floor. During an interview on 1/29/26 at 10:22 am with RN Nurse Instructor (NRS ED) 1 and RN Nurse Instructor (NRS ED) 2, NRS ED 1 and NRS ED 2 confirmed the urinary catheter bag should not be on the floor. NRS ED 2 stated, That is not what we teach. NRS ED 2 confirmed the facility does not have a specific policy for urinary catheter maintenance, but they teach and follow the Lippincott Nursing Procedure Manual. During a review of the professional reference titled, Lippincott Nursing Procedure 8th Edition published 2019, page 387 indicated, Don't place the drainage bag on the floor, to reduce the risk of contamination and subsequent CAUTI.</p> |                                                                                           |                                                 |

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| F 0865<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Have a plan that describes the process for conducting QAPI and QAA activities.</p> <p>Based on interview and record review, the facility failed to implement an effective Quality Assurance and Performance Improvement Plan (QAPI) program when the facility did not utilize the QAPI process to address the known absence of a licensed pharmacist since October 2025. This failure resulted in the potential for continued noncompliance with pharmacy service requirements due to the facility's failure to utilize its QAPI program to identify and correct the issue. Findings: During an interview with Skilled Nursing Facility Administrator (SNF Admin) on 1/29/26 at 10:34 am, SNF Admin stated the facility did not have a pharmacist in November 2025, December 2025, and January 2026. During an interview with Standards Compliance Coordinator (SCC) on 1/30/26 at 8:21 am, SCC stated the QAPI meetings occur at least quarterly and as needed. SCC stated the last QAPI meeting was on 10/30/25. SCC stated there were no specific issues that were discussed regarding pharmacy services. There was no plan created for pharmacy services during the meeting. SCC stated communication between leadership and headquarters regarding the termination of pharmacy services with the contracted pharmacy company was not discussed with other members in QAPI during the last meeting. During a review of the facility's QAPI plan dated 2/2025, indicated, .QAPI Purpose: The purpose of QAPI is to take a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving.</p> |                                                                                           |                                                 |