

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555919	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/14/2026
NAME OF PROVIDER OR SUPPLIER Imperial Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 100 East 2nd Street Imperial, CA 92251	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 and record review, the facility staff failed to limit Resident 25's as needed psychotropic medication to 14 days and did not re-evaluate the resident for appropriateness of the medication Hydroxyzine (used to help control anxiety and tension caused by nervous and emotional conditions) 25 mg (milligram). This failure had the potential for an increased risk of adverse effects related to prolonged use of antipsychotics [a class of prescription medications primarily used to manage symptoms of psychosis, such as hallucinations (seeing or hearing things that aren't there) and delusions (false, fixed beliefs)]. Per the facility admission record, Resident 25 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a complex chronic brain disorder that alters how a person perceives reality). On 5/13/26, a record review of Resident 25's physician orders was conducted. Resident 25's physician orders indicated on 1/26/26, Hydroxyzine 25mg every 12 hours as needed for paranoid schizophrenia was ordered without a length of therapy and re-evaluation order. On 5/14/26, a concurrent interview and record review was conducted with the director of nursing (DON). A record review of the current physician's order for Resident 25's Hydroxyzine order was not re-evaluated every 14 days as required. The DON stated it was her responsibility that all residents using PRN antipsychotic medications are re-evaluated after 14 days of use. The facility policy titled Medication Utilization and Prescribing, dated April 2018, indicated that the physician and staff will evaluate the rationale for existing medications that .are being used intermittently on a PRN basis.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility staff failed to complete a medication regiment review (MRR -a systematic check of all the medications and supplements you take, conducted by a pharmacist or doctor with the goal of promoting positive outcomes and minimizing adverse. consequences associated with medication) for one of six sampled residents (25). This failure had the potential for a medication error for Resident 25's nicotine patch (a medicated adhesive bandage worn on the skin to help people quit smoking or vaping). Per the facility admission record, Resident 25 was admitted to the facility on [DATE] with diagnoses that included tobacco use. Per Resident 25's physician orders, on 9/30/25, an order for Nicotine Transdermal Patch 24 hour (a medicated adhesive bandage worn on the skin to help people quit smoking or vaping) - Apply 1 patch transdermally one time a day smoking cessation and remove per schedule. On 5/13/26, a record review of Resident 25's MRR was conducted. An MRR dated 4/5/26 indicated that Resident 25's Nicotine patch order is missing dose e.g. 21 or 14 or 7mg/24 hours and missing the length of therapy. The physician signed and dated the MRR on 4/6/26. Another MRR dated 5/6/26 was reviewed for the same Nicotine patch order and indicated that Resident 25's Nicotine patch order is missing dose e.g. 21 or 14 or 7mg/24 hours and missing the length of therapy. On 5/14/26, a concurrent interview and record review was conducted with the director of nursing (DON). A record review of the current physician's order for Resident 25's nicotine patch indicated that the MRR was not completed. The DON agreed that the Nicotine patch order was missing the dosage. The DON stated that it was her responsibility that MRRs are completed. A review of the facility policy titled Medication Utilization and Prescribing, dated April 2018, indicated that .The physician and staff will identify significant factors that may affect medication effectiveness and medication-related problems .		