STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555938	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Care Center - Travis	1244 Travis Blvd Fairfield, CA 94533

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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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure professional standards of practice were followed for two of eight sampled residents (Resident 1 and Resident 8) when:Resident 1's blood pressure medication was administered without parameters (specific thresholds set by a doctor indicating when to administer or hold medications);Resident 3's hazardous medication (medication that can cause serious health problems requiring special handling to protect healthcare workers, residents, and the environment) was not handled safely during administration;Resident 8's vital signs (measurements of the body's most basic functions) were not taken before administration of blood pressure (BP) medications;Resident 8's blood pressure medication was administered outside the physician-ordered hold parameters;Resident 8's evening medications were not administered as ordered; and,Resident 8's elbow splint was not applied as ordered by the physician.These failures resulted in Resident 1 and Resident 8 receiving antihypertensive medication outside physician's hold parameters that could lead to Resident 1 and Resident 8 to experience a sudden drop in blood pressure and heart rate, the potential for Resident 1 and the licensed nurse getting exposed to side effects of hazardous medications, and for Resident 8's contractures to worsen. 1. During a medication pass observation on 12/2/25 at 11:36 a.m. outside of Resident 1's room with LN 1. LN 1 prepared and administered four medications and two supplements to Resident 1. One of the medications administered was one tablet of losartan 25 mg (used for high blood pressure). A review of Resident 1's clinical record indicated Resident 1 had the following physician order: - losartan oral tablet 25 milligram (mg, unit of measurement) give one tablet via PEG tube (percutaneous endoscopic gastrostomy, a feeding tube used to deliver nutrition, fluids and medications directly to the stomach) one time a day related to end stage renal disease (kidney failure), dated 11/29/25. It was scheduled daily at 11:00 a.m. The order did not include blood pressure (BP) hold parameters. BP hold parameters are clinical instructions indicating when to withhold high blood pressure medication based on the resident's current blood pressure. The absence of such hold parameters may increase the risk of low blood pressure and associated complications. During a concurrent interview and clinical record review on 12/2/2025 at approximately 3: 50 p.m. at the nursing station with LN 1, LN 1 was asked to provide the BP reading obtained prior to administering losartan. LN 1 stated the BP was108 [systolic blood pressure (SBP)] / 69 [diastolic blood pressure (DBP)] at 11:10 a.m., after Resident 1 returned from dialysis. A review of Resident 1's losartan 25 mg blister pack prescription was conducted at the medication cart at 4:03 p.m. with LN 1. The prescription, filled by the pharmacy on 10/30/2025 indicated, the following administration instructions: Hold for SBP less than 110. LN 1 stated the medication should (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been held, she then stated, I gave it. She confirmed that she did not clarify the order with the prescriber prior to administration. During an interview and record review on 12/4/2025 at 9:54 a.m. conducted with the Director of Nursing (DON) regarding the administration of blood pressure medications, DON stated that blood pressure medications should always include hold parameters. The DON reviewed Resident 1's clinical record, including the losartan order dated 11/29/25 and the medication administration record (MAR). She confirmed that the losartan was administered 12/2/25 without hold parameters on the day the resident had returned from dialysis. The DON stated that the nurse should have clarified the order due to the risk of hypotension [low blood pressure] following dialysis. A review of the facility's Policy and Procedure titled Administering Medications, revised April 2019 and effective 2025, stated: 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 or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber. to discuss the concerns. 2. During a medication pass observation on 12/3/25 at 8:52 a.m. outside of Resident 3's room. LN 4 was observed preparing a total of six medications for Resident 3, which included three tablets, two liquid medications and one liquid supplement. LN 4 retrieved a clear plastic bag from the medication cart. The bag had a yellow background and was labeled: CAUTION: Hazardous Drug. LN 4 removed the bottle from the bag with her bare hands. The amber prescription bottle was labeled with a yellow auxiliary sticker that indicated, hazardous medication. The prescription label indicated the bottle contained, valproic acid oral solution, 250 milligrams (mg unit of measurement /5 milliliters (mL unit of volume). LN 4 then poured 10 mL of the valproic acid liquid medication into a medicine cup with her bare hands. At 9:08 a.m. LN 4 donned gloves, entered Resident 3's room and proceeded to administer Resident 3's medication and supplement During an interview on 12/3/25 at 9:47 a.m. at the medication cart stationed outside of Resident 3's room with LN 4, when asked how to handle hazardous medication, LN 4 stated, gloves must be worn. When asked to review valproic acid medication bag and bottle, LN 4 confirmed the labeling on the bag indicated: CAUTION HAZARDOUS DRUG Follow Safety Precautions For Handling Administration & Disposal LN 4 then removed the bottle from the bag and confirmed Hazardous Medication was labeled on the bottle. She confirmed she did not wear gloves while preparing the hazardous medications and stated (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she did not notice it was hazardous. During an interview on 12/4/25 at 9:57 a.m. with the DON, when asked what her expectation for nurses handling hazardous medication, the DON stated, I expect the nurse to wear gloves. She stated the medication may be absorbed into the skin, it is to protect the nurse. During a review of UpToDate Lexidrug (an online medical resource for healthcare professionals) Valproic acid: Drug Information: Hazardous Drugs Handling Considerations. Accessed December 7, 2025. Indicated: Hazardous agent. Use appropriate precautions for receiving handling, storage, preparation, dispensing, transporting, administration and disposal. During a review of Safety Data Sheet ((SDS, a required, detailed document for hazardous chemicals that provides information on the hazards including physical and health risks, instruction for prevention and safe handling and guidance for handling emergency exposures), Spectrum, revised December 6, 2022, Valproic Acid indicated: Hazard statements: .Causes skin irritation.May damage fertility or the unborn child.Individual protection measures, such as personal protective equipment: .Hand protection Wear suitable gloves. 3. During a review of Resident 8's admission records, the records indicated Resident 8 was admitted to the facility in January 2025 with diagnoses that included cerebrovascular disease (conditions that affect the blood vessels and blood flow to the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body). Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 8 had severe cognitive impairment. A review of Resident 8's physician order, dated 5/3/25, indicated, .hydralazine [a medication used to treat high blood pressure]. 50 MG [milligrams, a unit of measurement].Give 1 tablet by mouth three times a day related to.HYPERTENSION [high blood pressure].Hold if SBP [systolic blood pressure, the force of blood when the heart contracts and pumps blood out] < [less than]110. During a review of Resident 8's Medication Administration Records (MARs) from May 2025 to July 2025, the MARs indicated there were no documented blood pressure readings prior to the administration of Resident 8's hydralazine. During a review of Resident 8's physician order, dated 4/15/25, the order indicated, Lisinopril [medication used to lower blood pressure and makes it easier for the heart to pump blood].20 MG.Give 2 tablet [sic] by mouth at bedtime for HTN [hypertension].hold for SBP less than 110 and HR [heart rate] less than 60. During a review of Resident 8's MARs from April 2025 to July 2025, the MARs indicated Resident 8's heart rates were not taken prior to administering lisinopril doses. During a concurrent interview and record review on 12/3/25 at 3:45 p.m. with the Director of Nursing (DON), the DON confirmed Resident 8 had orders for hydralazine and lisinopril, and both orders included hold parameters. The DON further confirmed that Resident 8's blood pressures were not taken before administering the hydralazine, and stated that the expectation for the nurses was to check the vital signs before giving antihypertensives and stated, .the orders should state that. During a follow-up interview and record review on 12/4/25 at 11:36 a.m. with the DON, the DON (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	confirmed Resident 8's physician order for lisinopril included hold parameters for the heart rate. The DON further confirmed Resident 8's heart rates were not taken prior to the administration of the lisinopril doses and stated the expectation was for nurses to take the heart rate before administering lisinopril to ensure Resident 8's heart rate was within parameters. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated 2025, the P&P indicated, .The following information is checked/verified for each resident prior to administering medications:.b. Vital signs, if necessary. During a review of the facility's P&P titled Hypertension – Clinical Protocol, dated 5/2023, the P&P indicated, .1. The staff and physician will periodically monitor the individual's blood pressure control and cardiac function (including complications) and the physician will adjust treatments accordingly. 4. During a review of Resident 8's MAR for July 2025, the MAR indicated an order for Lisinopril 20 mg one tablet by mouth at bedtime for hypertension, and to hold for SBP of less than 110 and HR less than 60. The MAR further indicated Resident 8's lisinopril was administered on 7/23/25 with BP of 108/82 mmHg [millimeters of Mercury, a unit of pressure measurement] and on 7/29/25 with BP of 106/60 mmHg. During a concurrent interview and record review on 12/3/25 at 3:45 p.m. with the DON, the DON confirmed Resident 8's lisinopril doses were administered on 7/23/25 and 7/29/25 even if Resident 8's BP was outside the physician-ordered parameters. The DON stated the nurses should have held the lisinopril doses because the SBPs were below 110 mmHg. The DON added that it was important to hold the lisinopril dose if the SBP was less than 110 mmHg because of the possibility of Resident 8 experiencing very low blood pressure. During a review of the facility's P&P titled Administering Medications, dated 2025, the P&P indicated, .4. Medications are administered in accordance with prescriber orders. 5. During a review of Resident 8's MARs from September 2025 to November 2025, the MARs indicated Resident 8's evening medications scheduled to be given at 9 p.m. that included Famotidine (used to treat and prevent too much acid in the stomach), Lisinopril, Atorvastatin (used to lower cholesterol levels in the blood), and Melatonin (a hormone that helps regulate the body's sleep cycle), were not administered on 9/7/25, 10/6/25, and 11/6/25. The MAR indicated the medications were not given because Resident 8 was asleep. During an interview on 12/2/25 at 3:15 p.m. with Licensed Nurse 3 (LN 3), LN 3 stated if a resident was asleep during the medication pass, she would try to wake the resident up but if the resident did not want to be bothered, LN 3 stated she will come back at a later time to offer the medication. LN 3 further stated if a resident was not able to take medications, the physician will be notified because .there are certain meds that they [residents] need to take, they [medications] are prescribed for a reason. During a concurrent interview and record review on 12/3/25 at 3:45 p.m. with the DON, the DON confirmed Resident 8's evening medications scheduled at 9 p.m. were not given on 9/7/25, 10/6/25, and 11/6/25 because Resident 8 was asleep. The DON confirmed there was no documented evidence that the medications were offered again to Resident 8 or if the physician was notified of the missed doses. The DON stated the expectation was for nurses to wait until the resident wakes up, and to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notify the doctor of the missed doses. During a review of the facility's P&P titled Administering Medications, dated 2025, the P&P indicated, .21. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. Licensed nurse will offer the refused mediation at least three times.Attending Physician must be notified of the refusal and will obtain another order for the actual time the medication is given. 6. During a review of Resident 8's physician order, dated 9/22/25, the order indicated, .RNA [Restorative Nursing Assistant] program for donning/doffing [process of applying and removing] of (L) [left] elbow extension splint [a brace that holds the elbow in a straight position]. Pt [patient] to wear (L) elbow splint 5x/wk [five times per week] for 4 hours or as tolerated.FOR CONTRACTURE [shortening or hardening of muscles leading to restricted mobility] MANAGEMENT; SEE.ADL [activities of daily living] SHEETS. During a review of Resident 8's ADL Task Sheet, dated 11/5/25 to 12/3/25, the sheet indicated Resident 8's left elbow splint was applied for 15 minutes for 23 times instead of 240 minutes as ordered. During a concurrent interview and record review on 12/3/25 at 3:35 p.m. with the DON, the DON confirmed that Resident 8 had a physician order to apply the left elbow splint for 4 hours or 240 minutes or as tolerated. The DON further confirmed that Resident 8's left elbow splint was applied for 15 minutes on multiple days between 11/5/25 and 12/3/25 and stated the RNA should have notified the nurse. The DON was not able to find any documented evidence from the nurses that indicated Resident 8 did not tolerate the splint for 240 minutes. The DON stated that the expectation was for the RNAs to notify the nurse if Resident 8 was having issues with the splint. During a review of the facility's P&P titled POLICY AND PROCEDURE ON RESTORATIVE NURSING CARE, dated 5/2023, the P&P indicated, .Restorative nursing care shall include the following procedures or techniques employed to promote a resident's ability to attain his or her maximum functional potential.3. Splint or Brace Assistance.staff have a scheduled program of applying and removing a splint or brace, assess the resident's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled and documented in the clinical record.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate hydration and nutrition was provided for two of eight sampled residents (Resident 1 and Resident 4) when:Resident 1's fluid restriction (FR- limiting daily intake of all liquids often due to kidney or heart conditions) order was not followed; andResident 4's weight refusals were not documented. These failures increased the potential for Resident 1 to experience fluid overload and for Resident 4 to have significant weight changes. 1.A review of the admission Record indicated Resident 1 was admitted [DATE] with diagnoses including end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed), attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). A review of Resident 1's physician order dated 12/1/25 indicated an order for 1300/24 hours ml [milliliters, unit of measurement] Fluid Restriction [FR]. A review of Resident 1's Intake and Output (I & O- the process of tracking all fluids consumed and excreted to maintain fluid balance) indicated Resident 1's intake was above 1300 ml/24 hours from 8/17/25 to 12/2/25. During an observation on 12/2/25 at 9:25 a.m., Resident 1 was not in her room. During an interview on 12/2/25 at 9:37 a.m., Licensed Nurse 1 (LN 1) stated Resident 1 went out for dialysis. In a follow up interview on 12/2/25 at 3:54 p.m., LN 1 confirmed Resident 1 had FR order of 1300 ml/24 hours. The LN 1 further confirmed the order did not specify how much fluid Resident 1 should receive per shift. The LN 1 added the PM (afternoon) shift nurse will calculate the amount of fluids Resident 1 receives for 24 hours. During a concurrent interview and record review on 12/3/25 starting at 3:55 p.m. with LN 2 and LN 3, the LN 2 stated Resident 1 had been on FR for a while. The LN 2 further stated she would notify the physician and the Registered Dietitian (RD) if Resident 1's fluid intake is over 1300 ml. The LN 3 stated the notification to the physician should be done weekly when Resident 1's fluid intake exceeds the fluid restriction order. The LN 3 confirmed Resident 1's total intake on 11/30 was 2060 ml, on 12/1 was 1960 ml, and on 12/2/25 was 1780 ml. which exceeded 1300 ml. The LN 3 further stated she does not remember notifying the physician when Resident 1's intake was over 1300 ml. During a telephone interview with the RD on 12/4/25 at 9:25 a.m., the RD stated her first encounter with Resident 1 was on 9/5/25 and Resident 1 was not on FR. The RD further stated she contacted the RD at the dialysis clinic and Resident 1 was placed on 1000 ml/24 hours FR. The RD confirmed Resident 1 was receiving more than the fluids ordered. The RD added she recently requested the dialysis clinic to increase Resident 1's FR order to 1300 ml/24 hours since the FR order was not strictly followed. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the Director of Nursing (DON) on 12/4/25 starting at 10:45 a.m., the DON stated Resident 1 was admitted with dialysis orders and peg tube [gastrostomy]. The DON further stated Resident was started on 1000 ml FR on 9/10/25, then on 9/17/25 the FR was changed to 1200 ml. The FR order was changed to 1300 ml on 11/27/25, then on 11/29/25 the FR was changed to 1200 ml and then back to 1300 ml on 11/29/25. The DON confirmed Resident 1's fluid intake was above the FR as ordered. The DON added her expectation was for licensed nurses (LNs) to follow Resident 1's FR order and if the fluids provided were above the FR order, the LNs should notify the physician and the dialysis clinic. A review of the facility's policy and procedure (P & P) updated 5/2023 and titled, POLICY AND PROCEDURE ON FLUID RESTRICTIONS indicated, It is this facility's policy to provide residents with appropriate fluid amounts specific to their needs to ensure prevention of complications that may result thereof from excessive amount of intake.Specific amount of fluid restrictions, as prescribed by the physician, shall be documented in the resident's medical record, with specific information on amount of fluids to be given by nursing and dietary.Plan of care reflecting fluid restriction and how fluids will be provided should be developed.Dietary Services Supervisor in consultation with Registered Dietitian shall assist nursing services in determining amount of fluid distribution in a 24-hour period.Monitor resident's compliance with prescribed liquid/fluid restrictions and report to physician as needed. A review of the facility's P & P updated 5/2023 and titled, POLICY AND PROCEDURE ON DIALYSIS CARE indicated, It is this facility's policy to provide standards of care to residents receiving dialysis care.Licensed nurse shall monitor resident's compliance with.fluid restrictions.Primary physician and/or dialysis unit physician shall be notified of resident's non-compliance with.fluid restrictions. 2. A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility in July 2025 with multiple diagnoses including chronic venous insufficiency (valves in the leg veins are weak causing blood to pool in the legs), morbid obesity (severe form of obesity signifying a high-risk level of body fat significantly impacting health), diabetes (too much sugar in the blood), and heart failure (heart does not pump blood as well as it should). A review of Resident 4's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 10/27/25, indicated Resident 4 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 4 was cognitively intact. A review of Resident 4's Order Summary Report, indicated order MONTHLY WEIGHTS ordered 8/30/25. A review of Resident 4's Progress Notes, dated 10/2/25, indicated . Resident refused to do monthly weight this AM despite encouragement and explanation of purpose . A review of Resident 4's Progress Notes, dated 11/4/25, indicated . Resident refused monthly weights with RNA [Restorative Nursing Assistant] . A review of Resident 4's clinical record on 12/2/25 at 1:17 p.m. indicated Resident 4's weight was 287 pounds on 7/22/25 and 287 pounds on 8/1/25. No further weights were documented in the clinical record. The clinical record did not indicate Resident 4 had refused weight in September 2025. During an interview on 12/2/25 at 4:40 p.m. with the Registered Dietitian (RD), the RD stated the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	expectation is that residents are weighed monthly by the RNAs who report the weight to the nurse. The RD stated Resident 4 had refused monthly weights since August 2025. The RD stated that if Resident 4 refused to be weighed it should be charted on the day she refused. The RD confirmed there was no documentation in Resident 4's clinical record that she had refused to be weighed in September 2025. During a joint interview on 12/3/25 at 9:09 a.m. with the Director of Nursing (DON) and RNA, RNA stated resident weights are taken upon admission, done weekly for 4 weeks, and then monthly thereafter or as ordered per physician. RNA stated if a resident refused to be weighed, will go back later or the next day and offer again. RNA stated if resident still refused, she would report it to the charge nurse. RNA stated she gives the weights to the Licensed Nurse (LN) who is supposed to put in the computer. RNA stated RNAs do not chart the weights in the computer. RNA stated weights are taken the first Wednesday of the month. The RNA stated Resident 4 should have been weighed on 9/3/25, 10/1/25, and 11/5/25, and had refused weight today on 12/3/25. The DON stated the Resident 4 refused to be weighed after 8/1/25. The DON stated her expectation is that the LN would chart in the progress notes if resident refused and the physician was notified of the refusal. During an interview on 12/3/25 at 1:04 p.m. with LN 1, LN 1 stated RNA takes residents' weights the first week of the month. LN 1 stated the RNA should notify the LN of any refusal and the LN should document the refusal in the progress notes. LN 1 stated Resident 4 refused weights all the time and it should be in the progress note that she refused. During a concurrent interview and record review on 12/3/25 at 2:54 p.m. with the DON, the DON acknowledged that there was no documentation in Resident 4's progress note of Resident 4's refusal to be weighed in September 2025. A review of the facility's Policy and Procedure (P&P) titled Weight Assessment and Intervention, revised 3/22, indicated . Resident weights are monitored for undesirable or unintended weight loss or gain .Residents are weighed upon admission and at intervals established by the interdisciplinary team . Weights are to be recorded by the Resident Care Coordinator (RCC)/ Designee in each unit's weight record chart and in the individual's medical record . On the first week of the month, the RNA will submit the weight report to the Resident Care Coordinator/Designee who will input the weights into the resident's individual's medical record . A review of the facility's P&P titled Policy and Procedure on Weights, updated 5/23, indicated .Upon admission- CNA and/or RNA shall obtain an admission height and weight of resident. Results of which will be recorded in the resident's medical record. Weights shall be monitored for four (4) weeks after resident's admission or re-admission . Once a month- facility shall obtain monthly weights for all residents . A review of the facility's P&P titled Charting and Documentation, dated 2025, indicated .All services provided to the resident .shall be documented in the resident's medical record . Documentation of procedures and treatments shall include care-specific details, including . whether the resident refused the procedure/treatment . notification of family, physician, or other staff .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, the facility failed to develop a system to ensure the safe and secure disposal and reconciliation for controlled substances (medications with a high potential for abuse and addiction) in accordance with federal and state regulations when:1. The consultant pharmacist was not present on site to witness the disposal of controlled substances for the month of [DATE].2. Controlled substance medications were not accurately accounted for on the Medication Administration Record (MAR) and the Controlled Drug Record (CDR, an accountability record) for one of two randomly selected residents (Resident 4).These failures resulted in an increased risk for controlled substance medication loss, misuse, and potential harm to residents.1. During an interview and record review on [DATE] at 8:40 a.m. with the Director of Nursing (DON). The DON described the facility's process for controlled substance destruction. She stated that when a resident's-controlled substance medications are discontinued, expired, or no longer needed, the nurse brings the medication and the corresponding CDR to her. The DON stated she documents receipt of the medication on the CDR and completes the following information on the Narcotic Destruction Log with the transferring nurse:-Resident's name, prescription number, medication name and strength, quantify of medication, date of transfer, signature of the transferring nurse and signature of the DON as the receiving party.The DON stated that the most recent destruction occurred on [DATE], with the facility's consultant pharmacist (CP) viewing the process remotely via Zoom (a video conferencing platform). During the destruction, the Unit Supervisor (US), was present in the DON's office. The DON stated that she placed the controlled substance medications into the bin, added hot water and kitty litter. Then she and the US signed the narcotic destruction logs along with the US. The logs were sent to the CP, who signed and faxed them back to the facility.A review of the Narcotic Destruction Logs with the DON indicated the following controlled substances were documented as destroyed on [DATE]: Hydrocodone/Acetaminophen 10 mg-325 mg, (a schedule II-controlled substance for the management of pain): quantity: 60 tablets Resident 5: Lorazepam (a schedule IV- controlled substance for the management of anxiety) 0.5 mg, quantity: 4 tablets Resident 1: Modafinil (a schedule IV-controlled substance for the management of excessive sleepiness) 200 mg, quantify: 5 tabletsDuring a phone interview with the CP on [DATE] at 1:42 p.m., the CP confirmed that the November destruction was conducted via Zoom with the DON and US. He stated that he believed this practice was acceptable due to a COVID-19-related waiver but was unable to provide documentation of a current waiver. The CP stated that the facility's process involves adding liquid to the bin containing the controlled substances to render them unusable. However, when asked if he witnessed the addition of liquid to the bin, the CP stated, I believe they did, but I am not certain.During a review of the facility's policy and procedure (P&P), titled, Controlled Substance Disposal, effective date, [DATE], indicated: A. The director of nursing, in collaboration with the consultant pharmacist, is responsible for the facility's compliance with federal and state laws and regulations in the handling of controlled medication . D.Controlled medications are disposed of in a manner which minimizes the risk of accidental exposure and/ or diversion.During a review of the facility's P&P, titled, Consultant Pharmacist Services Provider Requirements effective date, [DATE], indicated, .C. The consultant pharmacist agrees to render the required service in accordance with local, state, and federal laws, regulations .standards of practice, and professional standards of practice.During a review of California Code of Regulations, Title 22, Section 72371(c)(1), indicated: Drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be destroyed by the facility in the presence of a pharmacist and a registered nurse employed by the facility. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recorded in the patient's health record or in a separate log. Such log shall be retained for at least three years.During a review of the California Department of Public Health, (CDPH), All Facilities Letter(AFL), Suspension of Regulatory Enforcement of Specified Skilled Nursing Facility Requirements, (AFL-20.32.3) issued [DATE], indicated .temporary waiver of specified regulatory requirements due to the state of emergency related to the COVID-19 outbreak. effective [DATE]. this AFL will expire and this AFL will be rescinded.2. During a review of Resident 4's Medication Order Summary Report, indicated the physician order dated [DATE], which stated the following: Morphine (a narcotic medication to treat pain) 15 milligrams (mg, a unit of measurement) Give 7.5 mg (0.5 tablet) by mouth every 4 hours as needed for moderate to severe painThe CDR indicated morphine was removed from the medication cart on [DATE] at 5:00 p.m.A review of Resident 4's [DATE] MAR did not contain a corresponding documented administration for the removed morphine.During a concurrent interview and record review conducted on [DATE] at 9:11 a.m. with the DON, Resident 4's CDR and MAR dated [DATE] were reviewed, along with relevant nursing notes. The DON confirmed that the morphine dose removed on [DATE] was not documented in Resident's 4 MAR or in the nursing notes.During a review of the facility's P&P titled, Administering Medications, dated 2025, indicated, The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones.

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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. Based on observation, interview and record review, the facility failed to store and prepare food in accordance with industry standards when:Food was labeled inconsistently,The can opener tip was chipped but still in use, and The blue cutting board was deeply gouged. These failures had the potential of leading to cross contamination of the 6 residents eating facility prepared meals. 1. During the initial kitchen tour on 12/2/25 at 8:50 a.m. in the dry storage area, containers of bulk food items were stored in large plastic containers. One such container held long grain rice that lacked a received date or an opened date, but indicated a use by date of 5/22/35. Another container which held barley, also lacked a received date or an opened date, but indicated a use-by date of 12-6-35. During a concurrent interview of the Dietary Services Supervisor (DSS), the DSS concurred that the dates were close to 10 years away and believed they may coincide with the manufacturer's storage guidance but was unable to show the packaging to confirm this.Review of the Dry Goods Storage Guide hanging in the dry storage, indicated that opened barley should be discarded 6 months after opening, and that opened rice was to be discarded a year after opening,Review of the facility provided policy titled Labeling and Dating of Foods (Healthcare Menus Direct, LLC 2023) indicated that All food items in the storeroom . need to be labeled and dated. It further specified in the first bullet that Food delivered to facility needs to be marked with a received date. In the second bullet it communicated that Newly opened food items will need to be closed and labeled with an open date and used by date that follows the . Dry Goods Storage Guidelines.Review of facility provided policy titled Storage of Food and Supplies (Healthcare Menus Direct, LLC. 2023) indicated that Food and supplies will be stored properly and in a safe manner. In bullet 8 it specified that If you have product information about specific items . allowing a longer shelf life than the one in the Dry Food Storage Guidelines you can use that storage time instead. Keep that documentation on hand in case you are asked for it.2. During the initial kitchen tour on 12/2/25 at 9:30 a.m., the can opener was observed with a chip on the cutting tip. During a concurrent interview of the DSS, the DSS concurred that there was a chip. Review of the 2022 U.S. Food and Drug Administration Food Code, Section 4-501.11 on Good Repair and Proper Adjustment: inbullet C it indicated that the Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury.3. During the initial kitchen tour on 12/2/25 at 10:15 a.m., one of six cutting boards (the blue board used for fish and seafood) was observed with deep gouges on the cutting surfaces. During a subsequent interview with the DSS on 12/2/25 at 11:55 a.m., the DSS stated that it should have been replaced due to the gouges on the surface.Review of the 2022 U.S. Food and Drug Administration Food Code, Section 4-501.12 on Cutting Surfaces indicated that Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Cutting 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 foods that are prepared on such surfaces.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure proper treatment and care to maintain good foot health was provided for one of 8 sampled residents (Resident 8) when podiatry services (services focused on diagnosis, treatment, and prevention of conditions affecting the foot, ankle, and lower leg) were not provided for Resident 8 as ordered by the physician.This failure had the potential to result in Resident 8's decreased overall quality of life and well-being, and the potential for Resident 8 to experience discomfort.Findings:During a review of Resident 8's admission records, the records indicated Resident 8 was admitted to the facility in January 2025 with diagnoses that included cerebrovascular disease (conditions that affect the blood vessels and blood flow to the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body), dementia (a progressive state of decline in mental abilities), and Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 8 had severe cognitive impairment.During a review of Resident 8's physician order, dated 1/29/25, the order indicated, PODIATRY CARE Q2 MONTHS [every 2 months] PRN [as needed] DEBRIDEMENT OF HYPERTROPHIC MYCOTIC NAILS, CORNS AND/OR CALLOUSES [a procedure to remove thickened, damaged, or infected nails].During a review of the facility's PODIATRY VISIT SUMMARY, dated 5/20/25, 8/21/25, and 10/24/25, the summaries indicated that Resident 8 was not included on the list of residents who received podiatry services. During an interview on 12/3/25 at 2 p.m. with the Social Services Designee (SSD), the SSD confirmed Resident 8 had an order for podiatry services every two months and as needed. The SSD also confirmed that Resident 8 had a podiatry service visit on 3/18/25 and no visits were made thereafter. The SSD stated it was important for residents to have podiatry services provided because .it's their right to be comfortable and free from pain.During a concurrent observation and interview on 12/3/25 at 3:07 p.m. with Certified Nursing Assistant 1 (CNA 1) in Resident 8's room, Resident 8 was observed lying in bed awake and calm. CNA 1 asked Resident 8 for permission to see Resident 8's toenails and Resident 8 agreed. Resident 8's toenails on left and right big toes measured approximately one centimeter (cm, a unit of measurement) passed the toe and the rest of the toenails measured approximately half of a centimeter in length passed the toe, and CNA 1 confirmed Resident 8's toenails were long.During a concurrent interview and record review on 12/3/25 at 3:45 p.m. with the Director of Nursing (DON), the DON confirmed that Resident 8 had an order for podiatry care every two months as needed and that there were no podiatry visits done after 3/18/25. The DON further confirmed Resident 8 was not on the list of residents with podiatry consultations for the month of May and August 2025. The DON stated that nurses had to assess and document if Resident 8 did not have any issues that would require podiatry care.During a review of the facility's policy and procedure (P&P) titled POLICY AND PROCEDURE ON PODIATRY CARE & SERVICES, dated 5/2023, the P&P indicated, .Facility shall provide podiatry services to residents, as necessary based on comprehensive assessment and concurrent clinical diagnoses.7. Follow up consults and treatment would be obtained for at least once in every 60 days.8. Residents admitted without any foot problems, including those with clinical diagnosis of Diabetes Mellitus, would be referred to primary physician for necessary orders of podiatry consult and evaluation at least once in every 60 days.

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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, and record review, the facility failed to ensure oxygen use was documented consistently for one of eight sampled residents (Resident 3).This failure had the potential to not accurately assess Resident 3's need and response to oxygen therapy. A review of the admission Record indicated Resident 3 was admitted [DATE] with diagnoses including hemiplegia and hemiparesis (paralysis and weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain stroke- loss of blood flow to a part of the brain) affecting right dominant side, and gastrostomy status (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).A review of Resident 3's physician order dated 10/8/25 indicated an order for oxygen at 2 liters (L- unit of measurement) per minute via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) as needed for SOB (shortness of breath, oxygen saturation (O2 sats- measures how much oxygen the blood is carrying as a percentage) below 90 %, chest pain.A review of Resident 3's O2 sats summary from 10/8/25 to 12/2/25 indicated Resident 3 had oxygen saturation checked while Resident 3 was on oxygen and readings were above 90%. Further review indicated Resident 3's O2 sats were checked 11 times with oxygen for October, 38 times with oxygen for November, and 3 times with oxygen for December (12/1-12/2/25). A review of Resident 3's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) indicated Resident 3 received oxygen 3 times for October, received oxygen 3 times for November, and there was no oxygen use documented from 12/1 to 12/2/25.During an observation on 12/2/25 at 9:27 a.m., Resident 3 was lying in bed, eyes closed with ongoing oxygen at 2 liters per minute via nasal cannula and the head of bed was elevated. During an interview on 12/2/25 at 9:29 a.m., Certified Nursing Assistant 1 (CNA 1) stated Resident 3 uses oxygen as needed. The CNA 1 confirmed Resident 3 was currently on oxygen.During an interview on 12/2/25 at 9:43 a.m., Licensed Nurse 1 (LN 1) stated Resident 3 was provided with oxygen as needed when O2 sats were below 90%. The LN 1 confirmed Resident 3 was on oxygen at 2 liters per minute. In a follow up interview on 12/2/25 at 10:28 a.m., the LN 1 stated the oxygen use is documented under oxygen saturation. The LN 1 further stated if Resident 3 had been using oxygen it would be documented as oxygen via nasal cannula.In a subsequent interview with LN 1 on 12/2/25 at 10:34 a.m., the LN 1 stated Resident 3 was already on oxygen when she came in today at around 7 a.m. During a concurrent interview and record review on 12/2/25 at 3:18 p.m., the LN 1 stated the licensed nurse who started the oxygen for Resident 3 should be the one documenting the oxygen use. The LN 1 further stated her responsibility was to follow up if Resident 3's oxygen use was effective. Resident 3's O2 sats summary and MAR for December were reviewed with LN 1. The LN 1 confirmed the oxygen provided to Resident 3 on 12/1 and 12/2/25 was not documented in the MAR and the O2 sat summary for 12/2/25 did not indicate Resident 3 was on oxygen. During a concurrent interview and record review with the Director of Nursing (DON) on 12/4/25 10:20 a.m., the DON stated if the oxygen order is PRN [as needed] the licensed nurse should document in the progress notes when oxygen was administered. Resident 3's O2 sats summary, MAR, and progress notes were reviewed with the DON. The DON confirmed Resident 3's use of oxygen was not consistently documented by the LNs. The DON further stated oxygen use should be documented wherever it needed to be documented such as the MAR and progress notes. A review of the undated facility's policy and procedure titled, POLICIES AND PROCEDURES ON OXYGEN THERAPY indicated, It is this facility's policy to provide oxygen to residents, in a safe and therapeutic manner. Oxygen therapy shall be administered as ordered by the physician.It is the responsibility of the licensed nurse.to monitor and record resident's response to treatment. Documentation of such shall be in the licensed nurse progress notes and should include.Time of initiation of oxygen therapy.Amount of oxygen and delivery (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	method.Respiratory status before and after initiation of treatment.oxygen saturation level shall be obtained prior to administration of oxygen.Appropriate plan of care shall be developed to reflect current condition of resident and include use of oxygen.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on interview and record review, the facility failed to provide appropriate pain management for one of eight sampled residents (Resident 4) when Resident 4's pain level per pain scale assessment (a numerical system used to gauge a resident's pain intensity, where 0 is no pain and 10 is worst possible pain) did not correlate with pain medication provided. This failure had the potential for Resident 4's pain to not be treated effectively. A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility in July 2025 with multiple diagnoses including chronic venous insufficiency (valves in the leg veins are weak causing blood to pool in the legs), spinal stenosis in the lumbar region (narrowing of the spinal canal in the lower back that compressed nerves causing pain, weakness, or numbness in the legs and buttocks), and osteoarthritis (cartilage in joints is worn down causing bones to rub against each other causing pain and stiffness) of the left knee, ankle, and foot. A review of Resident 4's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 10/27/25, indicated Resident 4 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 4 was cognitively intact. A review of Resident 4's Care Plan . [Resident 4] has chronic pain r/t [related to] spinal stenosis, chronic knee pain r/t arthritis . date initiated 7/25/25, indicated Interventions .Administer analgesia tylenol and morphine as per orders . A review of Resident 4's Order Summary Report indicated orders:Morphine Sulfate [an opioid pain medication] ER Oral Tablet Extended Release 15 MG [Milligrams] .Give 1 tablet by mouth every 12 hours for Pain Management . start date 7/23/25, andMorphine Sulfate Oral Tablet 15 MG . Give 7.5 mg by mouth every 4 hours as needed for severe pain (scale 7-10) . start date 10/28/25, andTylenol [brand name for acetaminophen, a pain reliever] Oral Tablet 325 MG .Give 1 tablet by mouth every 4 hours as needed for mild pain (scale 1-3) . start date 10/28/25, andTylenol Oral Tablet 325 MG . Give 2 tablet by mouth every 4 hours as needed for Moderate pain (scale 4-6) . start date 10/28/25. A review of Resident 4's Medication Administration Record [MAR] for 10/1/25 to 10/31/25, indicated PAIN ASSESSMENT QSHIFT [EVERY SHIFT]: 0=NO PAIN, 1-3 MILD PAIN, 4-6 MODERATE PAIN, 7-10 SEVERE PAIN order date 7/21/25, discontinue date 10/29/25. A review of Resident 4's MAR for 10/1/25 to 10/31/25, indicated Morphine Sulfate .Give 7.5 mg by mouth every 4 hours as needed for Moderate to Severe pain . order date 7/23/25, discontinue date 10/28/25, was given on:10/10/25 for pain level of 5 and pain level of 10,10/12/25 for pain level of 5, and 10/20/25 for pain level of 5. A review of Resident 4's MAR, for 10/1/25 to 10/31/25, indicated Tylenol Oral Tablet 325 MG . Give 2 tablet by mouth every 4 hours as needed for Mild pain . order date 7/21/25, discontinue date 10/28/25, was given on:10/1/25 for pain level 8, 10/2/25 for pain level 5, 10/4/25 for pain level 5, 10/10/25 for pain level 7, 10/12/25 for pain level 7, 10/13/25 for pain level 6, 10/14/25 for pain level 5, 10/14/25 for pain level 5, 10/15/25 for pain level 6, 10/16/25 for pain level 6, 10/17/25 for pain level 4, 10/20/25 for pain level 5, 10/23/25 for pain level 5 and pain level 8, 10/25/25 for pain level 6, and10/28/25 for pain level 6. A review of MEDICAL DIRECTORS Summary of Pharmacist Recommendations, for Resident 4, dated 10/27/25, indicated .Although it is a positive clinically if pain is controlled by a lower potency analgesic, orders need to be followed. Current orders are APAP [Acetaminophen] 650 mg prn [as needed] mild pain (1-4, I presume) and for moderate to severe MS IR [Morphine Sulfate Immediate Release]. However there are 8 prn doses of APAP given when pain is noted as 6 or above and 5 more with pain level 5 which per your scale I believe triggers to moderate .In simple terms, to comply with this type of appearance, where the MS IR is being used more for severe pain, in other words change the APAP to prn mild to moderate, and the MS IR for severe breakthrough. Depends on what is best for her, but current system is not working best. During an interview on 12/2/25 at 10:19 a.m. with Resident 4, Resident 4 stated she has pain in her knees and receives morphine in the morning and evening and Tylenol if needed. During a concurrent interview and record review on 12/3/25 at 1:04 p.m. with Licensed Nurse (LN) 1, LN 1 stated pain scale is 1 to 3 for mild pain, 4 to 6 for moderate pain and 7 to 10 for severe (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain. Reviewed with LN 1 Resident 4's MAR for 10/1/25 to 10/31/25. LN 1 acknowledged that Resident 4 was receiving two tablets of Tylenol for pain level assessment that indicated moderate pain even though the order indicated two tablets for mild pain. LN 1 acknowledged that pain level assessment did not correlate with pain medication given. LN 1 stated the order was corrected on 10/29/25 to reflect two tablets of Tylenol for moderate pain and one tablet for mild pain. During an interview on 12/3/25 at 2:54 p.m. with the Director of Nursing (DON), the DON stated the Pharmacy Consultant (PC) notified the facility that Resident 4's Tylenol order in October was incorrect and the pain level assessment needed to be changed from mild pain to moderate pain. The DON acknowledged that the pain level of mild was not appropriate for the Tylenol dosage ordered. The DON stated the order was changed on 10/28/25. A review of the facility's Policy and Procedure (P&P) titled Pain Assessment and Management, not dated, indicated .The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain .The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice .Assessing Pain .Assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level .Pain management interventions shall reflect the sources, type and severity of pain . Monitor the resident by performing a basic assessment . with standardized assessment tools (e.g. approved pain scales, etc) . Document the resident's reported level of pain .in accordance with the pain management program .

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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. Based on interview and record review, the facility failed to ensure the pharmacy recommendation was implemented for one of eight sampled residents (Resident 1) when the site of the insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) injection was not documented.This failure had the potential for Resident 1 to receive insulin injections on the same site and for Resident 1 to develop thickened skin affecting insulin absorption. A review of the admission Record indicated Resident 1 was admitted with diagnoses including end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney (s) have failed), and type 2 diabetes mellitus (DM- disorder characterized by difficulty in blood sugar control and poor wound healing).A review of Resident 1's physician orders indicated Humalog injection as per sliding scale (a rapid-acting insulin is adjusted based on the current blood sugar level) subcutaneously (inject medication into the fatty tissue beneath the skin) every 6 hours and Insulin Glargine (long -acting insulin) 16 units subcutaneously at bedtime. A review of Medication Regimen Review (MRR) dated 8/28/25 for Resident 1 indicated, With INSULIN we should always include on the eMAR [electronic Medication Administration Record- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident].the spot for nursing to document the SITE of injection.Further review of the MRR dated 9/26/25 for Resident 1 indicated, PRIOR recommendation still needs some clarification so you have the SITE OF INJECTION noted on the record with every dose. This applies to both Humalog and Glargine.During a concurrent interview and record review with the Director of Nursing (DON) on 12/4/25 starting at 1:10 p.m., the DON stated MRR was done monthly by the Pharmacy Consultant. Resident 1's MRR and MAR were reviewed with the DON. The DON confirmed the following information during the MAR review from 9/2025 to 12/2025:-Humalog injection site was documented one time for September and Glargine injection site was not documented for September 2025;-Humalog injection site was documented for October and Glargine injection site was not documented from 10/29 to 10/31/25;-Humalog and Glargine injection site was not documented for November 2025; and, -Humalog and Glargine injection site was not documented from 12/1 to 12/4/25. In a follow up interview on 12/4/25 at 1:32 p.m., the DON stated her expectation was for Licensed Nurses to enter the insulin orders accurately which should include the site of injection. The DON further stated the facility did not act on the pharmacy consultant's recommendation timely.A review of the facility's policy and procedure (P & P) updated 5/2023 and titled, Insulin Administration indicated, To provide guidelines for the safe administration of insulin to residents with diabetes.Select an injection site.injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm).Documentation.Injection site.A review of the facility's P & P updated 5/2023 and titled, Nursing Care of the Resident with Diabetes Mellitus indicated, .Documentation should reflect the carefully assessed diabetic resident and include the following.Injection site rotation (if insulin is ordered).

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	555938	A. Building B. Wing	12/04/2025

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 3) was free of a significant medication error when staff did not flush the resident's gastrostomy tube (aka G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) as ordered by the physician and in accordance with the facility's policy and procedure. This failure resulted in the potential for tube clogging, which may disrupt the delivery of medication and nutrition, increasing the risk for complications such as dehydration, undernourishment and harm to the resident. During a medication observation on 12/3/25 at 8:52 a.m., Licensed Nurse (LN) 4 was observed preparing seven medication preparations for Resident 3 including four oral tablets, two liquid medications and one liquid nutritional supplement. LN 4 crushed each medication tablet, placed the contents in separate medication cups and diluted them. Then, she prepared the liquid formulations into separate medication cups. Afterwards she brought the preparations to the bedside. On 12/3/25 at 9:08 a.m., LN 4 attached a 60-mililiter (mL, unit of measurement) syringe to the resident's G-tube and checked the gastric residual volume (GVR). Then she removed the plunger and administered a 5 mL flush by gravity, followed by each medication and a subsequent flush. The medications were observed to drain slowly into the tube.On 12/3/25 at 9:28 a.m., the final medication (amber-colored liquid) failed to drain by gravity. At 9:30 a.m., LN 4 inserted the plunger and pushed the medication into the G-tube.During an interview on12/3/25 at 9:47 a.m. with LN 4, outside of the resident's room, she confirmed that she used a 5 mL flush before and between medications, and a 30 mL flush at the end. LN 4 acknowledged that she administered the last medication by pushing it through the tube because it was too sticky. She stated that best practice is to use gravity administration, as pushing medications through the tube poses a risk of rupture.A review of Resident's 3's Medication Administration Record (MAR), indicated an Enteral Feed Order, dated 9/29/25: every shift flush tube before and after medication administration with 30 cubic centimeters (cc) (unit of measure, equivalent to 30 milliliters [mL])During a follow-up interview and MAR review on 12/3/25 at 1:59 p.m. at the nurses' station, LN 4 confirmed that the 5 mL flush was given prior to the first medication rather than the 30 mL flush as ordered. The nurse stated it is important to give the flushes, so the tube won't clog.On 12/4/25 at 1:58 p.m., during an interview with the Director of Nursing (DON), in her office, she stated that nurses are expected to follow physician orders when administering medications via feeding tubes, including any specific prescribed flush volumes. She explained that the facility's protocol is to flush the feeding tube with 15 to 30 milliliters (mL) of water before and after medication administration, and 5 mL between medications. The DON stated that failure to flush the tube properly can result in tube clogging, which may prevent the resident from receiving the full dose of prescribed medications, adequate nutrition, and hydration. During a review of the facility's P&P, titled Medications through Gastrostomy Tube/Jejunostomy Tube, updated 5/2023, indicated, Procedures: 15. Remove piston from the catheter-tipped syringe and insert the catheter syringe into the gastrostomy tube. 16. Instill about 30-50 ml of water (follow MD orders for amount of water) into the syringe to flush the feeding solution through the tube and into the resident's stomach. This process allows checking of the tube's patency and to clear the tube before giving a drug through it. 17. Slowly pour up to 30 ml of the drug at a time into the syringe, using it as a funnel. 18. Allow the drug to flow slowly through the tube. If it flows too quickly, lower the syringe. If it flows too slowly, raise the syringe slightly. 19. As the syringe empties, add more of the drug.During a review of the facility's P&P, titled, Maintaining Patency of a Feeding Tube (Flushing), dated, 2025 indicated, under General Guidelines: For maintaining patency of a feeding tube: 3. Flush enteral feeding tubes with 15 -30 mL, or prescribed amount . before and after administration of medication. 4. Flush with 30 mL, or prescribed amount of warm water after checking gastric residual volume (GRV).During a review of the Journal of Parenteral and Enteral Nutrition ASPEN Safe Practices for Enteral Nutrition Therapy, dated 1/2017, the journal indicated, Feeding tubes are prone to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clogging.The risk of clogging may result from .insufficient water flushes . the article indicated the following practice recommendations, Provide appropriate tube irrigation around the timing of drug administration: a. Prior to administering medication, stop the feeding and flush the tube with at least 15 ml water.

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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, staff interview, and record review, the facility failed to ensure that a prepared medication was not returned to the medication cart for one of eight sampled residents (Resident 8).This practice resulted in prepared, unsealed, unlabeled medication being available for use, creating a risk for medication error and the potential for resident harm.During a medication pass observation with Licensed Nurse (LN 1) on 12/2/25 at 1:10 p.m., at the medication cart, LN 1 retrieved Resident 8's dose of hydralazine 50 mg (a medication used to treat high blood pressure) from a sealed, pharmacy-supplied blister pack. She popped the tablet into a medication cup, placed it in a plastic bag to crush it, then returned the crushed medication to the cup and mixed it with applesauce.LN 1 entered Resident 8's room and explained the medication was for hypertension (high blood pressure). The resident refused the medication despite several offers.On 12/2/25 at 1:21 p.m., LN 1 returned to the medication cart and stated that the resident refused [the medication]. She then labeled the medication cup with the resident's room number, covered it with a tissue, and placed it back in the medication cart.During a follow-up interview on 12/2/25 at 4:24 p.m., LN 1 confirmed that she labeled the medication cup covered it with a tissue and placed it back in the medication cart.During an interview on 12/4/25 at 10:04 a.m., with the Director of Nursing (DON), when asked about her expectations for returning prepared patient medications to the medication cart. The DON stated, no, you throw it away. During a review of the facility's policy and procedure (P&P) titled Medication Storage in the Facility, effective 11/14/2024, the P&P indicated that .contaminated, or deteriorated medications. or without secure closures are immediately removed from inventory.During a review of the facility's P&P titled Administering Medications, revised April 2019 and effective 2025, the P&P stated, . If medication is mixed with apple sauce, medication should be discarded and prepare another set when resident is ready to take.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure coordination of care between the hospice team (care designed to provide supportive care for physical, psychological, spiritual, and emotional needs to a terminally ill resident) and the facility for one of 8 sampled residents (Resident 6), when the resident's clinical records did not include hospice documents. This failure placed Resident 6 at risk for not receiving services necessary to promote comfort and quality of life. Findings: A review of the admission Record indicated the facility admitted Resident 6 in early 2025 with multiple diagnoses which included end stage heart failure (a condition when the heart becomes weaker and it's too weak to pump blood through the body effectively causing severe fatigue and shortness of breath). A review of Resident 6's clinical records contained a physician order dated 3/19/2025, which indicated Resident 6 was admitted to the hospice services. A review of Resident 6's electronic records and a Hospice Binder located at the nursing station was conducted on 12/3/25 at 12:15 p.m. Resident 6's records did not contain the resident's hospice Plan of Care (POC) which included Resident 6's medication list, physician orders, disciplines frequencies, and visit schedule. During a concurrent interview and record review on 12/3/25 at 12:30 p.m., Licensed Nurse (LN 4) stated Resident 6 has been receiving hospice services for a long time and explained that the resident had a designated binder which contained all hospice documents. Upon reviewing Resident 6's Hospice Binder, LN 4 acknowledged that the binder did not contain the resident's POC and only an incomplete visit calendar for March 2025. LN 4 stated that hospice nurses and aides usually visited Resident 6 two times a week, but the sign in sheet indicated that the last visit was dated 11/20/25, almost two weeks ago. LN 4 was not able to explain the process of communication between the facility and the hospice agency and stated the visit notes were not available for review. During an interview and record review on 12/3/25 at 12:45 p.m., Unit Supervisor (US) was asked to explain the coordination of care between the facility and hospice. The US stated, We always communicate with hospice and follow hospice plan of care. The US acknowledged that Resident 6's Hospice Binder did not contain the Plan of Care and the most current physician certification of terminal illness (CTI). The US validated that there was no visit calendar for the month of December which would show the dates of hospice staff scheduled to visit Resident 6. The US acknowledged that Hospice Binder contained Resident 6's medication list which was not accurate and contained medications that Resident 6 had not been taking since May 2025. A review of the facility's ?Policy and Procedure on Hospice Care,' dated 5/2023, indicated, It is the facility's policy to provide coordinated care and services to residents admitted under hospice care.The licensed nurse in charge of the care of the patient , in conjunction with the Director of Nurses, is responsible for coordinating hospice and non-hospice care. During a concurrent interview and record review on 12/3/25, at 2 p.m., the Director of Nursing (DON) stated there should be collaboration of resident's care between hospice and facility staff to ensure that hospice resident received the necessary care and services consistent with hospice philosophy. The DON acknowledged that every resident who received hospice services, should have a current POC, which included a calendar of assigned hospice staff, visit schedule and frequencies, sign in sheet for hospice staff, and visit notes. The DON validated that Resident 6's records and hospice binder did not contain Resident 6's Plan of Care and the medication profile in the binder was not accurate. The DON agreed that without communication from the hospice nurses, facility staff might not know the care needs of Resident 6 or any treatment changes. The DON stated social services was responsible for monitoring the hospice coordination of care including communication between the hospice and facility. During an interview on 12/3/25 at 2:48 p.m., the Social Services Designee (SSD) stated her responsibilities for coordination of care with hospice included offering resources and arranging for transportation or mortuary. SSD added, I am not a clinical person to coordinate resident's care. A review of ?Inpatient Service Agreement' between the (name of the hospice agency) (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and facility, dated 3/24/2024 indicated, Facility shall designate a member of the Facility's interdisciplinary team who is responsible for working with Hospice representatives to coordinate care to the residents provided by the Facility staff and Hospice staff. The interdisciplinary team member must have a clinical background, function within their scope of practice act and could assess the residents.The designated interdisciplinary team member is responsible for.Obtaining the following information from the Hospice.The most recent Hospice Plan of Care [POC], medication information and physician orders specific to each Hospice Patient residing at Facility.to maintain the Hospice Patient's highest practicable physical, mental, and psychosocial well-being.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to ensure performance improvement projects (PIP) were developed when high risk or problem-prone areas in the facility were not identified for a census of 8.This failure decreased the facility's potential to correct systemic issues that can affect residents' health and safety.Findings:During an interview on 12/4/25 at 4:24 p.m. with the Administrator (ADM), the ADM stated that during the facility's Quality Assurance and Performance Improvement (QAPI, a systematic approach to improving the quality of care and resident life in healthcare settings) meetings, the QAPI members present and discussed the most pressing issues within the facility. The ADM stated the QAPI team identified high risk and problem-prone areas including kitchen management during their monthly meetings. The ADM acknowledged that no PIPs were conducted to address the identified issues and stated, we could have picked a lot of projects to do the PIP. The ADM further stated that the QAPI team should have created a PIP based on the issues discussed during the QAPI meetings.During a review of the facility's policy and procedure (P&P) titled Quality Assurance and Performance Improvement (QAPI) Program, dated 5/2023, the P&P indicated, .4. Performance improvement projects: a. Performance improvement projects (PIPs) are initiated when problems are identified.b. PIPs involve systematically gathering information to clarify issues and to intervene for improvements.The following steps are employed or will be employed to support and enhance the facility QAPI program:.17. Prioritizing identified quality issues based on risk of harm and frequency of occurrence, and determining which will become the focus of PIPs.18. Planning, conducting, and documenting PIPs.