STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055121	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN RIDGE POST ACUTE	466 FLAGSHIP ROAD , NEWPORT BEACH, California, 92663

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during the Abbreviated Survey for Complaint Numbers: 2595718, 2596225, 2606142, 2612509, 2615859 and 2617940. The survey team entered the facility on 9/3/25 at 1340 hours. The facility identified the census as 145. The survey sample size was 18. Inspection was limited to the complaints investigated and did not represent the findings of a full inspection of the facility. * FOR COMPLAINT NUMBER 2595718, NO DEFICIENCIES WERE IDENTIFIED. * FOR COMPLAINT NUMBERS 2596225, NO DEFICIENCIES WERE IDENTIFIED. * FOR COMPLAINT NUMBER 2606142, DEFICIENCIES WERE IDENTIFIED AND CITED AT F655, F656, F684, AND F726. IN ADDITION, DURING THE ABBREVIATED SURVEY, DEFICIENCIES WERE IDENTIFIED AND CITED AT F698. * FOR COMPLAINT NUMBER 2612509, NO DEFICIENCIES WERE IDENTIFIED. HOWEVER, DURING THE ABBREVIATED SURVEY, ADDITIONAL DEFICIENCIES WERE IDENTIFIED AND CITED AT F695. * FOR COMPLAINT NUMBER 2615859, DEFICIENCIES WERE IDENTIFIED AND CITED AT F698.	F0000	**PLAN OF CORRECTION** The plan of correction is provided pursuant to California and Health and Safety Code, Section 1280; it is prepared and/or executed solely because it is required by the provisions of federal and state law. Submission of this Plan of Correction is not legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interests against the facility, the administrator, or any employees, agents or other individual who may be discussed in this response and plan of correction. In addition, preparation and submission of this plan of correction does not constitute an admission or an agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth by the survey agency. The submission of the plan of correction within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance of admissions by the facility. This plan of correction shall constitute this facility's credible allegation of compliance.	

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 reverse for further 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
MWalker	DON	10/23/25

POC Accepted 10/23/25

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F0000	Continued from page 1 *FOR COMPLAINT NUMBER 2617940, DEFICIENCIES WERE IDENTIFIED AND CITED AT F842. IN ADDITION, DURING THE ABBREVIATED SURVEY, DEFICIENCIES WERE IDENTIFIED AND CITED AT F657, F689 AND F755. GLOSSARY AND DEFINITIONS: % - percentage ADL - Activities of Daily Living Chest tube placement - a tube placed into the space around the lung to drain the accumulated fluid CNA - Certified Nurse Aide COC - Change of Condition CPAP - Continuous Positive Airway Pressure Day shift - 0700 to 1500 hours Dialysis/Hemodialysis- medical treatment that performs the filtering function of healthy kidneys when they fail, removing waste and excess fluid from the blood DON - Director of Nursing DSD - Director of Staff Development ESRD - End-Stage Renal Disease (condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products and excess fluid from the blood Flank - side of the abdomen, extending from the lower ribs to the hips H&P - History and Physical IDT - Interdisciplinary Team is a group of professionals with diverse expertise who work together towards a common goal, sharing their knowledge and skills to develop a holistic plan of care or solution for a complex problem. Left pleural effusion - a buildup of fluid in the space around the lung	F0000		

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F0000	Continued from page 2 LVN - Licensed Vocational Nurse MAR - Medication Administration Record MDS - Minimum Data Set (a tool for implementing standardized assessment in nursing homes and non-critical access hospital swing beds). MRD - Medical Records Director NOC shift - 2300 to 0700 hours P&P – Policy and Procedure Perma-Cath - a type of in-dwelling catheter that allows for the performance of hemodialysis Port-A-Cath - an indwelling vascular access that is typically implanted in the chest wall and used for long term vascular access to administer intravenous medications such as chemotherapy, transfusions or intravenous nutrition RN- Registered Nurse s/p - status post SNF- Skilled Nursing Facility	F0000		
F0655 SS = D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F0655	**F0655 - Baseline Care Plan** **Immediate Corrective Action:** On 09/02/2025, a treatment care plan was developed for Resident #10 Surgical site. **Residents Affected:** On 09/02/2025, the RN Supervisor reviewed all residents with pressure injuries and surgical sites from wound report to ensure that care plans were developed, reviewed, updated, and	

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F0655 SS = D	Continued from page 3 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on interview and medical record review, the facility failed to ensure the baseline care plan was developed to reflect the specific care needs for one of 18 sampled residents (Resident 10). * The facility failed to ensure a baseline care plan problem was developed to address Resident 10's surgical incision care upon admission to the facility. Resident 10 was admitted to the facility on 4/17/25, however, the facility had not assess, monitor and/or provide wound care to Resident 10's surgical incision until 9/2/25.	F0655	revised. No other residents were affected. **Corrective Action:** Licensed nurses were in-serviced by the DON, beginning on September, 3rd, 2025, on the process for developing, reviewing, and updating care plans for surgical sites. **Monitoring of Corrective Action:** The DON or their designee will review care plans for all new and all wounds in the weekly wound meeting to verify compliance. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0655 SS = D	Continued from page 4 This failure resulted in the resident's care needs not being met and had the potential to affect the resident's well-being. Findings: Medical record review for Resident 10 was initiated on 9/23/25. Resident 10 was admitted to the facility on 4/17/25, with a surgical wound on the left lateral thoracic (chest) region with three sutures. Review of Resident 10's Skilled Nursing Facility Transfer Orders (from the acute care hospital) dated 4/17/25, showed Resident 10 had an incision site on the left upper lateral chest with the dressing in place. In addition, under the Wound/Skin Care section showed to follow the current recommendations of the wound team for the treatment and follow the standard nursing protocols for the wound care. Review of Resident 10's Baseline Care Plan failed to show a baseline care plan problem was developed to address Resident 10's surgical wound and the provision of required care for the surgical wound with sutures. On 9/25/25 at 1130 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 10 was admitted to the facility with a surgical wound on the left lateral thoracic region with three sutures. The DON verified a baseline care plan problem was not developed within 48 hours of the resident's admission to the facility, to address Resident 10's surgical wound with sutures. On 9/26/25 at 1652 hours, a telephone interview was conducted with the Administrator and DON. The Administrator and DON verified was informed and verified the above findings. Cross reference F684.	F0655		
F0656 SS = B	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans	F0656		

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F0656 SS = B	Continued from page 5 §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and medical record review, the facility failed to develop and implement a	F0656	**F0656 - Develop and Implement Comprehensive Person-Centered Care Plan** **Immediate Corrective Action:** On September, 02, 2025, a treatment care plan was developed for Resident #10 for multiple refusals. **Residents Affected:** On September, 02, 2025, the RN Supervisor reviewed all residents with refusals to ensure that care plans were developed, reviewed, updated, and revised. No other residents were affected. **Corrective Action:** Licensed nurses were in-serviced by the DON, beginning on September, 03, 2025, on the process for developing, reviewing, and updating care plans for refusals care plan. **Monitoring of Corrective Action:** The DON or their designee will review care plans for all new and all wounds in the weekly wound meeting to verify compliance. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0656 SS = B	Continued from page 6 comprehensive person-center care plan for to reflect the individual care needs for one of 18 sampled residents (Resident 10). * The facility failed to ensure a care plan was developed to address Resident 10's refusal of multiple aspects of his plan of care. This failure had the potential to cause inappropriate and inadequate plans of care for the resident. Findings: Medical record review for Resident 10 was initiated on 9/23/25. Resident 10 was admitted to the facility on 4/17/25. Review of Resident 10's H&P examination dated 4/18/25, showed Resident 10 had the capacity to understand and make decisions. Further Review of resident's medical record showed Resident 10 was admitted with a surgical wound with sutures, which was not assessed, monitored, accurately documented or cared for until 9/2/25, at which point the wound was assessed and documented accurately, the sutures were removed and the resident began receiving wound care for other unrelated wounds that were discovered on 9/2/25. Review of Resident 10's Inter-Disciplinary Team note dated 9/2/25 at 1445 hours, showed Resident 10 refused ADL care and dialysis. On 9/23/25 at 1355 hours, an interview was conducted with the Wound Care Nurse. The Wound Care Nurse verified Resident 10 frequently refused all aspects of his plan of care, including skin assessment, dialysis for two weeks, which ultimately required hospitalization, medications and repositioning to prevent pressure injuries. The Wound Care Nurse stated he believed the resident's wound and sutures were not discovered for four and a half months after his admission to the facility due to his refusals of care. Review of Resident 10's Wound Care Note dated 9/24/25, showed Resident 10 had been refusing wound care and dialysis necessitating hospitalization.	F0656		

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F0656 SS = B	Continued from page 7 However, review of Resident 10's plan of care failed to show a care plan problem was developed to address the resident's refusal of multiple aspects of his plan of care, including frequent refusals of dialysis, repositioning, medications and assessment of his skin and wounds. On 9/24/25 at 1130 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified there was no care plan developed to address the resident's refusal of multiple aspects of his plan of care. The DON stated she believed the surgical wound was missed due to the resident's frequent refusal of skin assessment and care from the facility staff. The DON verified the resident's refusals should have been incorporated into the resident's plan of care. On 9/25/25 at 1000 hours, an observation and concurrent interview was conducted with the Wound Care Nurse for Resident 10. Resident 10 was observed refusing wound care. The Wound Care Nurse stated Resident 10 had refused his medications and dialysis that morning. On 9/26/25 at 1652 hours, a telephone interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.	F0656		
F0657 SS = B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F0657	**F0657 – Care Plan Timing and Revision** **Immediate Corrective Action:** On 09/25/2025 and 09/26/2025 a fall care plan was developed and updated for Resident #08. **Residents Affected:** On 09/25/2025, the RN Supervisor reviewed all residents with falls ensure that care plans were developed, reviewed, updated, and revised. No other residents were affected.	

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F0657 SS = B	Continued from page 8 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (III)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to revise the resident centered care plan for one of three sampled residents (Resident 8) reviewed for fall. * The facility failed to revise Resident 8's care plan and reassess the effectiveness of the interventions of Resident 8's care plan when Resident 8 fell on 9/14 and 9/16/25. This failure placed the residents at risk of not being provided appropriate, consistent, and individualized care. Findings: Review of the facility's P&P titled Fall/ Accident Mitigation and Intervention dated October 2024 showed the facility nursing staff and/or the IDT shall update the resident's plan of care accordingly, to reduce the risk of further occurrences of a fall or other event. Review of the facility's P&P titled General Documentation Guidelines dated 10/2024 showed it is the policy of this facility to document relevant findings in the clinical record specific to each individual resident's needs and condition. Medical record review for Resident 8 was initiated on 9/22/25. Resident 8 was admitted to the facility on	F0657	**Corrective Action:** Licensed nurses were in-serviced by the DON, beginning on September, 17th, 2025, on the process for developing, reviewing, and updating care plans for falls. **Monitoring of Corrective Action:** The DON or their designee will review care plans for all new and recently falls during IDT meeting. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0657 SS = B	Continued from page 9 5/7/25. Review of Resident 8's plan of care showed a care plan problem dated 5/7/25, addressing the resident's risk for fall. Review of Resident 8's plan of care showed a care plan problem revised 9/6/25, addressing the resident's actual fall incidents with no injuries. Review of Resident 8's progress notes showed the following documentation: - on 9/14/25 at 1903 hours, Resident 8 was found on the floor, next to the bedroom door; and - on 9/16/25 at 1303 hours, Resident 8 sustained two new skin tears due to a fall. However, further review of Resident 8's plan of care failed to show the care plan problem addressing the resident's actual fall incidents was revised and the effectiveness of the interventions was reassessed when Resident fell on 9/14 and 9/16/25. On 9/19/25 at 1452 hours, an interview and concurrent medical record review were conducted with RNs 2 and 3. RNs 2 and 3 verified Resident 8's care plan was not revised when the resident fell on 9/14 and 9/16/25. RN 2 stated the fall care plan must be revised to reflect the current resident status so the facility staff would have a guide for the resident's plan of care. On 9/23/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 8's care plan was not revised to address the resident's fall episodes 9/14 and 9/16/25. The DON stated the resident's care plan should have been updated and revised.	F0657	F0684 -- Quality Of Care **Immediate Corrective Action:** On 09/02/2025, treatment care was initiated immediately for Resident #10 Surgical site.	
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility	F0684		

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F0684 SS = D	Continued from page 10 residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and the facility P&P review, the facility failed to provide services to attain or maintain the highest practicable well-being for one of 18 sampled residents (Resident 10). * Resident 10 was admitted to the facility from the acute care hospital on 4/17/25, with a surgical incision with three stitches on his left lateral thoracic region. The facility failed to assess and monitor the surgical wound, note the presence of the stitches and provide wound care since the resident's admission to the facility until the wound was brought to the facility's attention on 9/2/25, by the resident's outpatient dialysis clinic. This failure resulted in a delay in identifying the resident's surgical incision and providing the care required, which had the potential to place the resident at harm for impaired healing and increased risk for infection. Findings: Medical record review for Resident 10 was initiated on 9/23/25. Resident 10 was admitted to the facility on 4/17/25. Resident 10 had left pleural effusion (a buildup of fluid in the space around the lung) and left chest tube placement (a tube placed into the space around the lung to drain the accumulated fluid) in the acute care hospital, which was removed on 4/16/25. Review of Resident 10's H&P examination dated 4/18/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Skilled Nursing Facility Transfer Orders (from the acute care hospital) dated 4/17/25, showed Resident 10 had an incision site on the left upper lateral chest with the dressing in place. In addition, under the Wound/Skin Care section showed to follow current recommendations of the wound team for treatment and follow standard nursing protocols for wound care.	F0684	**Residents Affected:** On 09/02/2025, the RN Supervisor reviewed all residents wounds to ensure that treatment care, orders and care plans were developed, reviewed, updated, and revised. No other residents were affected. **Corrective Action:** Licensed nurses were in-serviced by the DON, beginning on September, 3rd, 2025, on the process for immediately initiating treatment care and orders, developing, reviewing, and updating care plans for wounds and surgical sites. **Monitoring of Corrective Action:** The DON or their designee will review treatment orders for all new and all wounds in the weekly wound meeting to verify compliance. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0684 SS = D	Continued from page 11 Review of Resident 10's Admission Skin Assessment dated 4/17/25, showed the resident had a surgical incision with an intact dressing on left rear flank and present on admission. Review of Resident 10's progress notes for the Long Term Care Evaluation from 4/17 until 9/2/25, showed under the Skin Issue #001 section, the resident had a surgical incision on the left rear flank (side of the abdomen, extending from the lower ribs to the hips) with an intact dressing that was present on admission. In addition, the progress note showed "Skin issue has not been evaluated" regarding the resident's surgical incision. Review of Resident 10's Baseline Care Plan dated 4/17/25, failed to show a baseline care plan problem was developed to address Resident 10's surgical wound and the provision of required care for the surgical wound with sutures. Review of Resident 10's progress notes dated 9/2/25, showed documentation the Wound Care Nurse assessed the presence of a healed surgical incision on Resident 10's left rear flank with three sutures. The three sutures were removed upon the assessment on 9/2/25. On 9/22/25 at 1355 hours, an interview was conducted with the Wound Care Nurse. The Wound Care Nurse stated Resident 10 returned from the dialysis clinic on 9/2/25, and the dialysis clinic had informed the facility Resident 10 had a healed surgical incision on his left lateral flank with sutures present. The Wound Care Nurse then assessed the healed surgical incision and removed the three sutures at the time of the assessment. The Wound Care Nurse verified the surgical incision was fully healed and appeared to be at least several months old. On 9/22/25 at 1330 hours, an interview was conducted with Resident 10. Resident 10 stated the sutures had been in place for a long time before they were removed. Resident 10 stated prior to the removal of the sutures, he had told someone at the facility that the sutures had been in place for a long time. Resident 10 was unable to recall who he had spoken to regarding the sutures.	F0684		

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F0684 SS = D	Continued from page 12 On 9/22/25 at 1330 hours, an interview was conducted with Physician 1, who provided wound care for the resident for an unrelated issue in the same region of the body as the surgical incision. Physician 1 stated the surgical incision on the resident's left lateral flank was in a location that would be easily visible to anyone providing care, such as bathing or cleaning, since the resident who required maximum assistance for his ADL care. On 9/25/25 at 1130 hours, an interview was conducted with the DON. The DON verified the above findings and stated the licensed nurses were required to fully assess the resident's skin on admission to the facility, readmission and weekly, if there were no concerns. The DON verified the direct care staff were required to assess the resident's skin when bathing, changing or repositioning the resident. The DON verified the discharge instructions from the acute care hospital for Resident 10's wound care dated 4/17/25. The DON verified the facility failed to assess, monitor, and provide care for the resident's surgical incision with sutures, that was present on admission. On 9/26/25 at 1652 hours, a telephone interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to one of three sampled residents (Resident 8)	F0689	**F0689 – Free of Accident Hazards/Supervision/Devices** **Immediate Corrective Action:** On 09/23/2025 and 09/25/2025 change of condition, neurocheck, care plan, post fall assessment initiated and MD and responsible party was notified. **Residents Affected:** On 09/23/2025, the RN Supervisor reviewed all residents with falls to ensure that change of condition, neurochecks, care plan, post fall assessment initiated and MD and responsible party was notified. No other residents were affected.	

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F0689 SS = D	Continued from page 13 reviewed for fall. * The facility failed to provide the necessary care and services for Resident 8 who had a fall on 9/14 and 9/16/25, including the assessment of the resident's change in condition, neurological assessments and post fall assessments after the falls. In addition, the facility failed to notify the physician and the resident's representative of the fall incidents. This failure had the potential to delay the identification and treatment of a possible fall-related injury and posed the risk of additional falls and injury to the resident. Findings: Review of the facility's P&P titled Fall/Accident Mitigation and Intervention dated October 2024 showed the following: - After a fall or other similar accident or occurrence, the resident shall have a physical assessment documented in the nursing notes in accordance with the facility documentation policy. The attending physician and legal representative or interested family member (if any) shall be notified of the event. - The facility shall begin 72-hour charting after the fall or related accident and continue to assess for latent injuries or changes in condition in accordance with the policy. - After proper assessment of the resident, and the resident is stable, notify the physician and resident representative (if there is one). Once the resident is stable, the facility staff member in charge will complete a report and forward to management as per the facility policy. - The facility nursing staff and/or the IDT shall update the resident's plan of care accordingly, to reduce the risk of further occurrences of a fall or other event. Review of the facility's P&P on Neurological Assessment dated October 2024 showed it is the policy of this facility to provide neurological assessments as indicated for the resident involved in an incident or with a condition that may warrant assessment of his/her neurological status. This may include, or not be limited to an unwitnessed fall, resident found on	F0689	**Corrective Action:** Licensed nurses were in-serviced by the DON, beginning on September, 15th 2025, on the process for all resident with witnessed or unwitnessed falls. **Monitoring of Corrective Action:** The DON or their designee will review all witnessed and unwitnessed falls in 24 hours to ensure all steps has been taken. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0689 SS = D	Continued from page 14 floor, or if there is an incident where the resident has hit his or her head. Neurological Checks are completed within the time frames noted on the Neuro Check Flow Sheet or as ordered by the physician. Review of the facility's in-services provided by the DSD titled Fall Prevention/ Falls given to the facility staff on 5/5, 7/31, 8/11, 8/26, and 9/15/25, showed a fall is an event in which an individual unintentionally comes to rest on the ground, floor or other level, but not as a result of an overwhelming external force. The event may be witnessed, reported or presumed when a resident is on the floor or the ground and can occur anywhere. Review of Resident 8's medical record was initiated on 9/19/25. Resident 8 was admitted to the facility on 5/7/25. Review of Resident 8's progress note dated 9/14/25 at 1903 hours, showed the resident was found on floor next to the bedroom door. Resident 8 reported no pain or discomfort and was able to make needs known verbally with the vital signs within parameters. Further review of Resident 8's progress notes showed a Skin Issues Note with an effective date of 9/16/25 at 1303 hours, regarding the resident's s/p (status post) fall and with two new skin tears due to the fall. Further review of Resident 8's medical record failed to show the following: - the assessment and documentation of the resident's change in condition, addressing the resident's fall incidents on 9/14 and 9/16/25; - the neurological assessment documentations after the falls on 9/14 and 9/16/25; - the 72 hour post fall monitoring and documentation after the falls on 9/14 and 9/16/25; - the pain assessment after the resident's fall on 9/16/25; - the skin assessment after the resident's fall on 9/14/25; - the IDT assessment and review after the resident's falls on 9/14 and 9/16/25;	F0689		

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F0689 SS = D	Continued from page 15 - the physician notification regarding the resident's fall on 9/14/25; and - the resident's representative notification regarding the resident's fall on 9/14 and 9/16/25. On 9/19/25 at 1433 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 reviewed Resident 8's medical record and verified the above findings. RN 2 stated it was important to complete the post fall follow- up documentation to check if there were any changes in the resident's condition. On 9/19/25 at 1452 hours an interview and concurrent medical record review was conducted with RN 3. RN 3 reviewed Resident 8's medical record and verified the resident's progress note on 9/14/25, regarding the resident's fall did not show full assessment of the resident's change in condition. RN 3 verified there were no neurological assessments, assessments for the skin, pain, and fall risk, and 72-hour post fall monitoring and documentation completed after the resident's fall incidents. In addition, RN 3 verified the physician was not notified of the fall on 9/14/25, and the resident's representative was not notified of the fall incidents on 9/14 and 9/16/25. RN 3 stated the MRD and DON checked and reviewed the documentation for completion and accuracy. On 9/22/25 at 845 hours, an interview and concurrent medical record review was conducted with RN 1 for Resident 8. RN 1 stated Resident 8's unwitnessed falls were related to his behavior of getting up unassisted. However, RN 1 stated the assessments (for the pain, neurocheck, skin and post- fall risk) were still done. RN 1 stated the resident did not exactly have a fall, but the nursing staff monitored Resident 8 for getting up unassisted and the licensed nurses did not complete the follow up notes because they monitored him every day. RN 2 showed the resident's behavior monitoring record, which was incomplete. On 9/22/25 at 950 hours, an interview and concurrent medical record review was conducted with LVN 2. LVN 2 stated on 9/16/25, she was told Resident 2 sustained skin tears due to a fall during shift change from the NOC shift to the day shift. LVN 2 stated she checked the resident and documented her findings in the Skin	F0689		

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F0689 SS = D	Continued from page 16 Assessment section of the resident's medical record. LVN 2 further stated she was not aware of the specifics of the fall. LVN 2 verified there was no documentation, including the COC (change of condition), IDT, post fall monitoring, and post fall assessments done addressing the resident's fall on 9/16/25. LVN 2 stated "yes," when asked if there should assessments and documentation done to address the fall. On 9/22/24 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 8's falls were considered a behavior, and an IDT meeting in May 2025 was held to address Resident 8's fall incidents. The DON stated the plan was to monitor Resident 8's behavior of getting up unassisted and record the number of times the behavior was manifested every shift. The DON stated when Resident 8 was found on the floor, it was not considered a fall because it was a behavior. The DON added a fall was when a resident tripped and fell. The DON stated the facility only completed the progress notes and monitoring and if indicated, the neurocheck assessment for unwitnessed incidents. The DON reviewed Resident 8's medical record and verified Resident 8's medical record did not show the COC documentation, IDT notes, the assessments for the neurocheck, pain, skin and post fall, family and physician notification and the post fall monitoring for 72 hours for the resident's fall on 9/14/25 fall. In addition, the DON verified Resident 8's medical record did not show the progress notes, COC documentation, IDT notes, the assessments for the neurocheck, pain, and post fall, family notification and the post fall monitoring for 72 hours for the resident's fall on 9/16/25. On 9/23/25 at 1507 hours, a follow up interview was conducted with the DON. When the DON was asked what her professional definition of fall was, the DON stated, "anything when the part of the body is touching the ground, it's a fall." When the DON was asked regarding Resident 8's incident of being found on the ground, if the incident was considered a fall, the DON stated "yes."	F0689	**F0695 - Respiratory/Tracheostomy Care and Suctioning** **Immediate Corrective Action:** On September,19th, 2025, the RN Supervisor changed the tubing for Resident #4's CPAP and properly labeled/stored the tubing.	
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(l) § 483.25(l) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs	F0695		

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F0695 SS = D	Continued from page 17 respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of 17 sampled residents (Residents 4 and 5). * The facility failed to ensure Resident 4's CPAP (Continuous Positive Airway Pressure. It is a treatment that uses a machine to deliver mild air pressure through a mask, which prevents the upper airway from collapsing during sleep. This is the most common treatment for a condition called obstructive sleep apnea) mask was stored in a sanitary manner. * The facility failed to provide a CPAP machine to Resident 5. These failures had the potential to affect the respiratory health and well-being of the residents in the facility. Findings: Review of the facility's P&P titled Oxygen Administration revised 11/2021, showed it is the policy of this facility that oxygen therapy be administered upon a physician order or, in the event of an emergency, by a licensed nurse or respiratory therapist. 1. Medical record review for Resident 4 was initiated on 9/19/25. Resident 4 was admitted to the facility on 7/23/25. Review of Resident 4's Order Summary Report showed the following orders: - dated 9/10/25, CPAP use at bedtime for sleep apnea every night shift. - dated 9/10/25, CPAP change or clean intake filter,	F0695	**Residents Affected:** On 9/19/2025, all residents on CPAP were observed by the RN Supervisor to verify compliance. No other residents were affected. **Corrective Action:** Licensed staff were and Inservice re-educated on respiratory care procedures by the DON on 09/19/2025 on the facility policy and procedure, for oxygen administration/CPAP. **Monitoring of Corrective Action:** The DON or their designee will perform daily room rounds to verify compliance with the CPAP administration policy and procedure. Identify deficient practices will corrected by the DON or designee. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0695 SS = D	Continued from page 18 and disposable supplies per manufacture guidelines or if soiled every evening and night shift. On 9/19/25 at 0940 hours, during an observation, Resident 4's CPAP mask was on the floor, and the bag to place the CPAP mask was not in Resident 4's room. On 9/19/25 at 1005 hours, an observation and concurrent interview was conducted with LVN 4. LVN 4 picked Resident 4's CPAP mask off the floor and placed it into a pink basin. LVN 4 verified there was no plastic bag to store the CPAP mask. LVN 4 stated the risk of the CPAP mask being on the floor could be a risk for infection. 2. Medical record for Resident 5 was initiated on 9/19/25. Resident 5 was admitted to the facility on 9/11/25. Review of Resident 5's Order Summary Report showed an order dated 9/11/25, for CPAP at bedtime for obstructive sleep apnea (sleep disorder characterized by repeated episodes of partial or complete blockage of the upper airway during sleep). Review of Resident 5's care plan for ineffective breathing pattern related to obstructive sleep apnea dated 9/17/25, showed interventions including to apply at CPAP at bedtime, evaluate lung sounds, evaluate for shortness of breath, and to monitor for periods of apnea while sleeping. On 9/19/25 at 1022 hours, an observation and concurrent interview was conducted with Resident 5. There was no CPAP machine in Resident 5's room. Resident 5 stated she has not had a CPAP machine since she was admitted to the facility. On 9/19/25 at 1027 hours, an observation, interview and concurrent medical record review was conducted with RN 2. RN 2 verified Resident 5 had an order for CPAP to be applied every night. RN 2 further verified there was no CPAP at Resident 5's bedside, and Resident 5 was not receiving the CPAP treatment. On 9/19/25 at 1044 hours, an observation, interview and	F0695		

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F0695 SS = D	Continued from page 19 concurrent medical record review was conducted with the DON. The DON verified the CPAP mask for Resident 4 should not have been on the floor. The DON further verified Resident 5 did not have the CPAP machine and was not receiving the CPAP as ordered by the physician. On 9/26/25 at 1652 hours, the Administrator and the DON acknowledged the above findings.	F0695	**F0698 - Dialysis Care and Services** **Immediate Corrective Action:** Resident #10, #18-DON began in servicing licensed nurses on proper documentation pre and post dialysis, correct access site on 09/23/25, and ensuring that resident receive dialysis treatment from outpatient center 09/23/25.	
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed ensure the dialysis care was provided for two of four sampled residents (Residents 10 and18) reviewed for dialysis. * The facility failed to ensure Resident 10's dialysis access was assessed accurately as ordered by the physician. * The facility failed to ensure Resident 18 received the dialysis treatment in an outpatient dialysis center as ordered by the physician. These failures had the potential for the residents not being provided with the appropriate care and treatment, and the possibility of medical complications related to dialysis. Findings: 1. Review of the facility's P&P titled Care of Dialysis Resident dated October 2024 showed it is the policy of the facility to provide nursing care to the dialysis resident in accordance with the physician orders.	F0698	Resident #10-DON began in servicing licensed nurses on proper documentation of the dialysis site 09/23/25. **Residents Affected:** All dialysis residents were assessed and their communication forms were completely filled out with accurate site and information on 09/23/25. No other residents were affected. **Corrective Action:** Nursing staff were re-educated / in-service by the DON on 09/23/2025 on policy and procedure for dialysis care, ensuring that the resident receive dialysis treatment from outpatient center and proper documentation of the dialysis site. **Monitoring of Corrective Action:** The DON or their designee will perform weekly audits on dialysis residents to ensure policy and procedure on dialysis care is followed and proper documentation for the access sites, monitoring to ensure that resident receive dialysis treatment from outpatient center.	

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F0698 SS = D	Continued from page 20 Review of Resident 18's medical record was initiated on 9/23/25. Resident was admitted to the facility on 9/3/25. Review of Resident 18's H&P examination dated 9/4/25, showed Resident 18 had the capacity to understand and make decisions. Review of Resident 18's Order Summary Report showed a physician's order dated 9/3/25, for hemodialysis Mondays-Wednesday-Fridays and Dialysis Center 1. Review of Resident 18's progress notes for the scheduled dialysis days on 9/5, 9/8, and 9/10/25, failed to show Resident 18 left the facility for dialysis as ordered by the physician. However, Resident 18's progress notes on 9/8/25 at 1746 hours written by LVN 5, showed Resident 18 arrived at 1730 hours from the dialysis center with incomplete dialysis information. Review of the facility's investigation regarding Resident 18's missed dialysis was completed on 9/12/25. The investigation concluded Resident 18 did not go to his scheduled dialysis and the reason why resident did not go was not known since Resident 18 was transferred to the acute care hospital on 9/9/25 at 1900 hours. On 9/23/25 at 1245 hours, a telephone interview was conducted with Dialysis Center 1 Facility Administrator. Dialysis Center 1 Facility Administrator stated Resident 18 was not dialyzed on site from 8/25 through 9/12/25. Dialysis Center 1 Facility Administrator further stated the SNF had called and was told Resident 18 could not make it to the dialysis center because the facility was unable to arrange transportation. On 9/23/25 at 1300 hours, an interview and concurrent medical record review was conducted with the Director of Business Development (DBD), who works with the Admissions Department. The Director of Business Development stated she confirmed the resident's transportation and dialysis center arrangements prior to and on the day of Resident 18's admission to the facility.	F0698	identified deficiencies will be corrected immediately by designee. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0698 SS = D	Continued from page 21 On 9/24/25 at 1040 hours, an interview was conducted with CNA 6, who was assigned to care for Resident 18 on 9/5 and 9/8/25, on the day shift. CNA 6 stated "I remember him, and on my days with him, he did not go to dialysis." CNA 6 further stated "I did not dress him up to go outside" and verified he was assigned to care for Resident 18 on 9/5 and 9/8/25. CNA 6 was asked if he saw Resident 18 leaving the building on the above dates, CNA 6 stated "I don't remember him leaving the building." On 9/25/25 at 0923 hours, an interview was conducted with the Receptionist. The Receptionist verified she worked on 9/5 and 9/8/25. The Receptionist stated she remembered Resident 18 and did not see him waiting in the lobby for his dialysis or any appointment. The Receptionist further stated if Resident 18 was in the lobby and not picked up, she would call the CNA or the licensed nurse. On 9/25/25 at 1214 hours, an interview and concurrent medical record review were conducted with LVN 5. LVN 5 stated she worked on 9/8/25, and did not physically see Resident 18 leave the building. LVN 5 further stated she did not see Resident 18 on his wheelchair arriving to the facility from an appointment and only saw him lying on bed in his room. When LVN 5 was asked if she was sure Resident 18 went to dialysis on 9/8/25, LVN 5 responded "I am not 100 % sure, it's a blur. I did not see him coming in. I should have asked the resident, asked the CNA and called the front desk, if he had dialysis." 2. Medical record review for Resident 10 was initiated on 9/23/25. Resident 10 was admitted to the facility on 4/17/25. Resident 10 had a diagnosis of end-stage renal disease (condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products and excess fluid from the blood) and had a Perma-Cath (a type of in-dwelling catheter that allows for the performance of hemodialysis) on in his left thigh. Review of Resident 10's Dialysis Communication dated 9/2/25, showed Resident 10's vascular access device was incorrectly specified as a Port- A-Cath. Review of Resident 10's Order Summary Report dated 9/23/25, showed a physician's order dated 9/21/25, for	F0698		

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F0698 SS = D	Continued from page 22 Resident 10's dialysis access site monitoring, which was specified as a Port-A-Cath (an indwelling vascular access that is typically implanted in the chest wall and used for long term vascular access to administer intravenous medications such as chemotherapy, transfusions or intravenous nutrition). On 9/25/25 at 1500 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 10's physician's order incorrectly specified the resident's Perma-Cath dialysis access site as a Port-A-Cath. The DON verified Resident 10's dialysis access was a Perma-Cath. On 9/26/25 at 1652 hours, a telephone interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.	F0698		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides.	F0726	**F0726 – Competent Nursing Staff** **Immediate Corrective Action:** On 09/02/2025, a treatment care plan was developed for Resident #10 Surgical site. All Licensed Competency Skill Check was initiated immediately. **Residents Affected:** On 09/02/2025, the RN Supervisor reviewed all residents with pressure injuries and surgical sites to ensure that care plans were developed, reviewed, updated, and revised. No other residents were affected. **Corrective Action:**	

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F0726 SS = D	Continued from page 23 The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and facility document review, the facility failed to ensure the licensed nurses and certified nursing assistants (CNA) had specific competencies and standard of practice skill sets needed to provide the safe and efficient nursing care to the residents as evidenced by: * Resident 10 was admitted on 4/17/25, with a surgical incision with three sutures that was not assessed, monitored or had care provided from the date of admission until 9/2/25, when the wound was brought to the attention of the facility by the resident's outpatient dialysis clinic. This failure had the potential to put the Resident 10 at risk for care not provided in a safe and competent manner. Findings: Medical record review for Resident 10 was initiated on 9/23/25. Resident 10 was admitted to the facility on 4/17/25. Resident 10 had left pleural effusion (a buildup of fluid in the space around the lung) and left chest tube placement (a tube placed into the space around the lung to drain the accumulated fluid) in the acute care hospital, which was removed on 4/16/25. Review of Resident 10's H&P examination dated 4/18/25, showed Resident 10 had the capacity to understand and make decisions. Review of Resident 10's Skilled Nursing Facility Transfer Orders (from the acute care hospital) dated 4/17/25, showed Resident 10 had an incision site on the left upper lateral chest with the dressing in place. In addition, under the Wound/Skin Care section showed to follow current recommendations of the wound team for treatment and follow standard nursing protocols for wound care.	F0726	~~Licensed nurses were in-serviced by~~ the DON, beginning on September, 3rd, 2025, on the process for developing, reviewing, and updating care plans for surgical sites, and skills competency. **Monitoring of Corrective Action:** The DON or their designee will review care plans for all new and all wounds in the weekly wound meeting the same week to verify compliance and continue with skill competency every month. If deficiencies are identified, the DON or their designee will immediately revise the care plan. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0726 SS = D	Continued from page 24 Review of Resident 10's Admission Skin Assessment dated 4/17/25, showed the resident had a surgical incision with an intact dressing on left rear flank and present on admission. However, further review of Resident 10's medical record showed the wound was not assessed by the facility staff until 9/2/25, at which time the wound was assessed and the sutures were removed. Resident 10 required maximum assistance with all his ADL care and therefore received care from multiple licensed nurses and CNAs per each shift in the facility. Resident 10's surgical wound was in an easily visible location on his left lateral flank and was documented on weekly progress notes as present, covered by an intact dressing and not evaluated until 9/2/25. On 9/25/25 at 1110 hours, an interview and concurrent facility document review was conducted with the DSD. The DSD verified the facility's skills competencies check off for the CNAs and licensed nurses did not include the skin assessment. The DSD verified the skin assessment was a required competency for the CNAs and licensed nurses. The DSD verified multiple direct care staff per each shift from the date of admission until 9/2/25, missed to assess and accurately document the resident's surgical wound. The DSD stated the resident's surgical wound was missed by multiple licensed nurses and CNAs because they were not performing the skin assessments as they were required to do. On 9/25/25 at 1130 hours, an interview and concurrent facility document review was conducted with DON. The DON verified the facility's skills competencies for the CNAs and licensed nurses did not include the skin assessment. The DON verified the skin assessment was a required competency for the CNAs and licensed nurses. The DSD verified multiple direct care staff per each shift from the date of admission until 9/2/25, missed to assess and accurately document the resident's surgical wound. The DON stated the resident's surgical wound was missed by multiple licensed nurses and CNAs because they were not performing the skin assessments as they were required to do. On 9/26/25 at 1652 hours, a telephone interview was conducted with the Administrator and DON. The Administrator and DON were informed and verified the above findings.	F0726		

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F0726 ~~F0755~~ SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to follow the physician's order for one of 18 sampled residents (Resident 11). * The facility failed to administer lidocaine patches to Resident 11 per the physician's order. This failure had the potential to negatively impact the resident's well-being. Findings:	F0726 F0755	~~F0755 - Pharmacy~~ **Services/Procedures/Pharmacist/Records** **Immediate Corrective Action:** On 09/03/25- In accordance with the facility's general documentation guidelines Lidocaine patch administration was recorded on the MAR for Resident #11. All medication errors for the residents identified in the citation were immediately corrected, the physician was notified, and residents were assessed for adverse outcomes. On 09/03/2025- In accordance with the facility's general documentation guidelines and count sheet was created to ensure all Lidocaine patches are administered. **Residents Affected:** On 09/04/2025 the RN Supervisor and designee reviewed the MAR and ensure all Lidocaine patches administered. No residents were identified as being affected at this time. **Corrective Action:** All licensed nursing staff were re-educated/Inservice on safe medication administration practices, including the "5 Rights" (right resident, right drug, right dose, right route, and right time) . **Monitoring of Corrective Action:** The DON or their designee will perform weekly med pass observations for 12 weeks, focusing on safe practices and documentation accuracy and review medication	

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F0755 SS = D	Continued from page 26 Review of the facility's P&P titled Medication Orders dated 4/2008 showed medications are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe. Review of the facility's P&P titled Preparation and General Guidelines-Medication Administration dated 10/2017 showed the following: a. medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so; b. medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications; c. medications are administered in accordance with written orders of the attending physician; d. medications are administered at the time they are prepared. Medications are not pre-poured; e. medication supplied for one resident are never administered to another resident; f. the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. Medical record review for Resident 11 was initiated on 9/3/25. Resident 11 was readmitted to the facility on 8/14/25. Review of Resident 11's H&P examination dated 8/17/25, showed Resident 11 had the capacity to make medical decisions. Review of Resident 11's Order Summary Report showed the following orders: - dated 8/17/25, Asperflex Lidocaine (pain relieving patch) 4.0% patch to be applied to lower back topically one time a day for pain management and remove per	F0755	disposition record logs to verify compliance. Visual checks that patches has been applied to the residents. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed. Completion Date: 10/25/2025	

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F0755 SS = D	Continued from page 27 schedule - dated 8/15/25, Lidoderm patch 5% (Lidocaine) (pain relieving patch) apply to right hip one time a day for pain management for 30 days. Review of Resident 11's MAR for September 2025 showed the following dates and times: - on 9/1/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/1/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/1/25 at 2100 hours, Asperflex Lidocaine 4.0% patch, lower back patch was removed - on 9/1/25 at 2100 hours, Lidoderm patch 5% patch on right hip was removed - on 9/2/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/2/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/2/25 at 2100 hours, Asperflex Lidocaine 4.0% patch, lower back patch was removed - on 9/3/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/3/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/2/25 at 2100 hours, Lidoderm patch 5% patch on right hip was removed Review of the facility's document titled Manifest dated 8/16/25, showed Resident 11 had a quantity of 14 Lidocaine 5% patches, and a quantity of 10 Asperflex Lidocaine 4% patches delivered to the facility. On 9/3/25 at 1509 hours, an observation and concurrent interview was conducted with Resident 11. Resident 11 asked a licensed nurse for his lidocaine patch. The licensed nurse left and did not return. Resident 11 stated he did not receive his lidocaine patches on 9/2 and 9/3/25.	F0755		

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F0755 SS = D	Continued from page 28 On 9/3/25 at 1701 hours, an observation and concurrent interview was conducted with the DON. The DON verified the lidocaine patch for Resident 11 was not applied. The DON verified the 4% Asperflex was not in Medication Cart 1, and the 5% Lidocaine patch contained 14 patches. On 9/25/25 at 1509 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated the Lidocaine 5% patch was found in central supply but was not refilled in the medication cart. The DON verified the medication cart containing 14 patches of Resident 11's 5% lidocaine. The DON stated since Resident 11 was not administered his lidocaine patch, the new process was to perform count sheets since the documentation showed Resident 11 received his patch but was not applied. On 9/26/25 at 1540 hours, an interview with Pharmacy 1 was conducted. Pharmacy 1 verified the facility received 10 Asperflex 4% patches and 14 Lidocaine 5% patches on 8/15/25 for Resident 11. Pharmacy 1 verified there were no other deliveries for the patches. On 9/26/25 at 1652 hours, the Administrator and the DON acknowledged the above findings. Cross reference to F842.	F0755	**F0842 – Resident Records-Identifiable Information** **Immediate Corrective Action:** On 09/03/25- In accordance with the facility's general documentation guidelines Lidocaine patch administration was recorded on the MAR and monitoring getting up unassisted for Resident #8 & #11. All medication errors for the residents identified in the citation were immediately corrected, the physician was notified, and residents were	
F0842 SS = B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-Identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain	F0842		

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F0842 SS = B	Continued from page 29 medical records on each resident that are- (I) Complete; (II) Accurately documented; (III) Readily accessible; and (IV) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (I) To the individual, or their resident representative where permitted by applicable law; (II) Required by Law; (III) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (IV) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (I) The period of time required by State law; or (II) Five years from the date of discharge when there is no requirement in State law; or (III) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F0842		

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F0842 SS = B	Continued from page 30 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical records were complete and accurate for two of 18 sampled residents (Residents 8 and 11). * The facility failed to ensure Resident 8's Monitor Record was accurate and complete. *The facility failed to ensure Resident 11's MAR was accurate. These failures had the potential for Resident 8 and 11's care needs not being met as the medical records were inaccurate. Findings 1. Review of the facility's P&P titled General Documentation Guidelines dated 10/2024 showed it is the policy of this facility to document relevant findings in the clinical record specific to each individual resident's needs and condition. Review of Resident 8's Order Summary Report showed a physician's order dated 5/21/25, to monitor for the behavior of getting up unassisted and record the number of times the behavior was manifested every shift. Review of Resident 8's Progress Note dated 9/14/25,	F0842	assessed for adverse outcomes. On 09/03/2025- In accordance with the facility's general documentation guidelines and count sheet was created to ensure all Lidocaine patches are administered. **Residents Affected:** On 09/04/2025 the RN Supervisor and designee reviewed the MAR and ensure all Lidocaine patches administered, complete, accuracy and properly stored. No residents were identified as being affected at this time. **Corrective Action:** All licensed nursing staff were re-educated/inservice on safe medication administration practices, including the "5 Rights" (right resident, right drug, right dose, right route, and right time). All resident records were audited by Medical Records Director and DON to verify accuracy, completeness and proper storage on 09/04/2025. **Monitoring of Corrective Action:** The DON or their designee will audit 5 random resident records weekly for 4 weeks, then Q2monthly for 6 months to ensure compliance, focusing on safe practices and documentation accuracy and proper storage and handling of medication. The results of these audits will be presented to the QAPI Committee on a quarterly basis for further monitoring and/or action planning as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055121	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PELICAN RIDGE POST ACUTE	466 FLAGSHIP ROAD , NEWPORT BEACH, California, 92663

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F0842 SS = B	Continued from page 31 showed the resident was found on the floor next to the bedroom door. The resident reported no pain or discomfort, and was able to make needs known. The resident's vital signs were within normal limits. Review of Resident 8's Skin Assessment dated 9/16/25, showed Resident 8 sustained two new skin tears due to fall. Review of Resident 8's Monitor Record for September 2025 showed the following: - there were no entries on 9/4, 9/5, 9/6, and 9/20/25, for the monitoring of the behavior of getting up unassisted and recording the number of times the behavior was manifested every shift. - there was inaccurate documentation on 9/14 and 9/16/25, when it was coded as 0 incidents of getting up unassisted instead of two incidents per above. On 9/23/25 at 1000 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the missing entries in the Monitor Record on 9/4, 9/5, 9/6 and 9/20/25. The DON stated Resident 8 had history of putting himself on the floor and those instances should have been documented on those dates. The DON also verified the entries on 9/14 and 9/16/25 were inaccurately documented as 0 because the resident got up unassisted and experienced unwitnessed falls on those dates. The DON stated the instances should have been documented as two instead of 0. On 9/25/25 at 1440 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified the above undocumented and inaccurate entries and stated the nurses did not complete the documentation. 2. Review of the facility's P&P titled Preparation and General Guidelines-Medication Administration dated 10/2017 showed the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented.	F0842		

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F0842 SS = B	Continued from page 32 Medical record review for Resident 11 was initiated on 9/3/25. Resident 11 was readmitted to the facility on 8/14/25. Review of Resident 11's Order Summary Report showed the following orders: - dated 8/17/25, Asperflex Lidocaine (pain relieving patch) 4.0% patch to be applied to lower back topically one time a day for pain management and remove per schedule - dated 8/15/25, Lidoderm patch 5% (Lidocaine) (pain relieving patch) apply to right hip one time a day for pain management for 30 days. Review of Resident 11's MAR for September 2025 showed the following dates and times: - on 9/1/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/1/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/1/25 at 2100 hours, Asperflex Lidocaine 4.0% patch, lower back patch was removed - on 9/1/25 at 2100 hours, Lidoderm patch 5% patch on right hip was removed - on 9/2/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/2/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/2/25 at 2100 hours, Asperflex Lidocaine 4.0% patch, lower back patch was removed - on 9/3/25 at 0900 hours, Lidoderm patch 5% patch applied to right hip - on 9/3/25 at 0900 hours, Asperflex Lidocaine 4.0% patch applied to lower back - on 9/2/25 at 2100 hours, Lidoderm patch 5% patch on right hip was removed On 9/3/25 at 1509 hours, an observation and concurrent interview was conducted with Resident 11. Resident 11	F0842		

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F0842 SS = B	Continued from page 33 asked a licensed nurse for his lidocaine patch. The licensed nurse left and did not return. Resident 11 stated he did not receive his lidocaine patches on 9/2 and 9/3/25. On 9/3/25 at 1701 hours, an observation, interview and concurrent medical record review was conducted with the DON. The DON verified the lidocaine patch for Resident 11 was not applied, and was documented it had been applied on 9/2 and 9/3/25 on Resident 11's MAR. On 9/26/25 at 1652 hours, the Administrator and the DON acknowledged the above findings. Cross reference to F755	F0842		