

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Ventura Avenue Chowchilla, CA 93610	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately and appropriately act on a significant change of condition on 7/7/26 for one of five residents (Resident 1) in accordance with professional standards of practice and facility's policy and procedure when Resident 1 was admitted to the facility on [DATE] for rehabilitation and on 7/6/26 Resident 1 was alert, cooperative, progressing with care goals, and was able to ambulate 25 feet. Resident 1 experienced an acute clinical decline the morning of 7/7/26 when staff noted Resident 1 was difficult to arouse from sleep, refused to get up and not able to ambulate, refused meals, and was found to have a high blood sugar. Nursing did not accurately provide the clinical decline assessment to the physician. Staff notified the physician about the elevated blood sugar but did not notify the physician of the extent of the clinical decline. On 7/7/26 the physician ordered the administration of insulin for the high blood sugar, for staff to re-check blood sugar after administering insulin, and monitor Resident 1. On the morning of 7/8/26, Resident 1 was found unresponsive with shallow breathing, low blood pressure, and low pulse and could not be aroused with vigorous sternal rub (A physical test used to determine if a person can wake up or feel pain. This is done by making a fist and firmly rubbing your knuckles up and down the chest bone for a few seconds). Certified Nursing Assistant (CNA) 1, who found Resident 1 to be unresponsive, twice requested Licensed Vocational Nurse (LVN) 4 to assess Resident 1's change in condition and LVN 4 did not assess Resident 1. When LVN 4 did not assess Resident 1, CNA 1 then called LVN 2, who ultimately assessed Resident 1 and initiated a transfer to the hospital for further evaluation. These failures resulted in not providing the expected level of quality of care and delayed treatment of Resident 1's clinical decline. Resident 1 was transported to the emergency department (ED) of the local hospital and admitted to the intensive care unit (ICU- (unit that specializes in close monitoring, and life support for people with severe, life-threatening illnesses or injuries) where he was admitted for eight days and intubated (a life-saving medical procedure where a tube is placed into the windpipe to assist with breathing using a machine) for respiratory failure (when lungs can't move oxygen in or out). Resident 1 was diagnosed with urosepsis (a life-threatening medical emergency caused when a urinary tract infection [UTI] spreads to the kidneys and causes a harmful body-wide response), acute kidney injury (kidneys suddenly lose their ability to filter waste from the blood), encephalopathy (damage or disease that affects the brain), pleural effusion (buildup of excess fluid between the layers of tissue that line the lungs and the chest), tachycardia (increased heart rate of more than 100 beats per minute at rest) and hypertension (high blood pressure). Resident 1 has been in the acute care hospital for 28 days and remains there currently. Findings: During a review of Resident 1's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 1 was admitted to the facility on [DATE] with (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 0684 Level of Harm - Actual harm Residents Affected - Few	and suffering. FM stated that the facility staff could have done more for Resident 1 or identified the immediacy of the situation when FM voiced the concerns of Resident 1's health decline on 7/7/26. FM stated that Resident 1 was alert, awake and walking before this incident but now he was not. During review of Resident 1's hospital document titled, Physical Therapy, Occupational Therapy, Speech Therapy, dated 6/15/26, the document indicated, . [Resident 1] has good prognosis for discharge to skilled nursing facility (a special type of licensed medical facility that provides 24 hour nursing care, medical treatment, and physical therapy) for short term rehabilitation. During a review of the Resident 1's hospital records titled, Discharge Summary, dated 6/30/26, the records indicated, . Urology (a medical and surgical specialty focusing on the urinary tract) consulted and foley catheter placed. recommend continue foley catheter at time of discharge. diabetes and hypertension controlled. labs stable, hemodynamically stable (a person has a stable blood flow, normal blood pressure, and a steady heart rate that safely supply blood to all major organs), patient at clinical baseline (an initial measurement or health state recorded before a treatment or study begins) can be discharge to skilled nursing facility. The record indicated Resident 1 was discharged from the hospital on 6/30/26 to the facility, with no complications and a recommendation to continue with the foley catheter for urination. During a concurrent interview and record review on 7/24/26 at 10:17 a.m. with the Director of Nurses (DON), Resident 1's, Change of Condition (COC) Evaluation, dated 7/7/2026 and 7/8/2026, were reviewed. The COC dated 7/7/26 indicated, . List the other change, altered mental status with hyperglycemia (high blood sugar), this started on 7/7/26, Vital signs evaluation. Pulse 109 regular. sudden change in level of consciousness or responsiveness. needs more assistance with activities of daily living. Resident has altered mental status. elevated blood sugar 337 (normal range is 70-100 before eating and 70-140 after eating). The document indicated nursing staff did not document Resident 1's significant decline in alertness, refusal of meals, decline in activity and level of cooperation with care. DON stated that on 7/8/26, Resident 1 was transferred to the hospital after CNA 1 found him unresponsive. The DON stated CNA 1 had entered Resident 1's room for breakfast and attempted to wake Resident 1 and CNA 1 discovered Resident 1 was unresponsive. The DON stated CNA 1 immediately informed LVN 4 of her findings. The DON stated that due to LVN 4's lack of urgency and assessment of Resident 1 after repeated requests from CNA 1, the DON stated LVN 4 was terminated for not completing an assessment of Resident 1 on the morning of 7/8/26 when Resident 1 was unresponsive. During a concurrent interview and record review on 7/24/26 at 11:14 a.m. with the Director of Rehabilitation (DOR), Resident 1's, Physical Therapy Treatment Encounter Notes, dated 7/2/26-7/7/26 were reviewed. The notes indicated, . Date of Service 7/2/26, summary of daily skilled services. skilled interventions focused on bed mobility (functional movements a person makes to change and adjust their body position while lying in bed) training to increase functional skills, training in supine (back)/side lying to/from sitting edge of bed and training in safe sit to stand to sit mobility. The [Resident 1] performed bed mobility tasks with moderate assistance and sit to stand with maximal assistance. Date of service 7/3/26. Gait (walking) training with four wheeled walker for 25 feet with minimal assistance. skilled interventions focused on transfer training to increase functional task performance and strengthening activities. the [Resident 1] performed bed mobility tasks with moderate assistance and transfers with moderate assistance. Date of service 7/6/26, [Resident 1] performed therapeutic exercises in sitting using ankle weights to develop strength and facilitate independence. [Resident 1] performed exercises. with rest breaks. compliant with skilled interventions. Date of service 7/7/26. [Resident 1] performed transfers with maximal assistance with 2 staff. [Resident 1] had more difficulty following commands today. Communicated decline to nursing and DON. The DOR stated that upon Resident 1's arrival at the facility, Resident 1 (continued on next page)		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	was for the nurse to complete an assessment, notify the physician, resident representative, follow physician orders and continue to monitor the resident. The DON stated if the resident's condition changed or declined, the process was to complete an assessment and notify the physician of the findings again. The DON stated this process applied to any change in conditions identified for all residents. The DON stated after reviewing Resident 1's documents and sequence of events leading to his hospital transfer, she believed that the nurses caring for Resident 1 on 7/7/26, followed the facility process and notified the physician. The DON stated she believed the failure occurred the morning of 7/8/26, when LVN 4 failed to respond to CNA 1's request for assessment when CNA 1 found Resident 1 unresponsive. During a telephone interview on 7/27/26 at 3:53 p.m. with the registered nurse (RN), the RN stated she had admitted Resident 1 to the facility and had reviewed the hospital discharge records prior to arrival to the facility. The RN stated that upon Resident 1's arrival to the facility, Resident 1 already had a foley catheter in place for urine retention. The RN stated she had obtained a physician order to remove the catheter for a 24-hour trial and monitoring to see if Resident 1 was able to urinate without the catheter. The RN stated, Resident 1 was incontinent (lack of voluntary control over urination) and using a brief therefore the nurses were able to observe Resident 1's briefs were wet with urine and determined that Resident 1 was able to urinate on his own without the catheter. The RN stated that on the morning of 7/7/26, she was called by LVN 1 due to Resident 1's change in condition regarding high blood sugar. The RN stated Resident 1 was assessed by LVN 1 and the physician was notified of Resident 1's change in blood sugar levels. The RN stated at the time of Resident 1's change in health, based on the assessment completed by LVN 1, it was believed that his condition had changed due to elevated blood sugar. The RN stated knowing the outcome of the change in condition, there were other factors that should have been assessed such as the refusal of meals and change in alertness. The RN stated that there were no indications that Resident 1 was experiencing urine retention at the time of the assessment and showed no signs of infection. During a review of Resident 1, Emergency Department (ED) Notes, dated 7/8/26, the notes indicated, . Chief complaint altered mental status, respiratory distress. brought Emergency department from [facility name] for altered mental status. Emergency medical services [EMS] reports staff at facility reported [Resident 1] was not behaving like his normal self however they were unable to tell what his baseline is. In route [Resident 1] blood pressure was 279 systolic (part of the measure of blood pressure that measures the force of blood against your artery walls when your heart beats, this is typically under 140) and he was tachycardic (fast heart beat). History unobtainable from [Resident 1] secondary to severity of condition. Physical Exam, first vital signs: blood pressure, 92/54 (normal is around 120/80), heart rate 172 (how many times your heart beats per minute-normal is 60-100), respiratory rate 50 (how many times you breath per minute-normal is 12-20), oxygen saturation 97 % oxygen method bagging (manual artificial ventilation using a bag and mask to push air into a person's lungs when they are unable to breathe on their own). cardiovascular: rapid irregular rate, shallow diminished bilateral breath (person is barely breathing). Diagnosis this visit: Atrial Fibrillation, poorly controlled Diabetes mellitus, shingles (painful blistering viral infection caused by the same pathogen that causes chicken pox), hypertension, benign prostatic hyperplasia with urinary obstruction (occurs when an enlarged prostate gland squeezes the urethra [tube that carries urine out of your body], causing trouble starting a urine stream, and weak flow and incomplete bladder emptying), acute kidney injury, sepsis (a life threatening medical emergency that happens when the body has an extreme, harmful reaction to an infection), altered mental status, urinary tract infection. Intent to admit Intensive care unit (unit that specializes in close monitoring, and life support for people with severe, life-threatening illnesses or injuries) . The note indicated Resident 1 was (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/27/2026
NAME OF PROVIDER OR SUPPLIER Palms Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 Ventura Avenue Chowchilla, CA 93610	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0684 Level of Harm - Actual harm Residents Affected - Few	admitted to the emergency department in critical condition with multiple areas of health decline including assistance with breathing and severe infection. During a review of the facility's Lesson Plan titled, Change of Condition, undated, the lesson plan indicated, . Recognizing and responding to a change of condition of residents. A change of condition is any decline or improvement in a resident's physical, mental, emotional, or functional status that differs from their normal baseline. Early recognition prevents complications, reduces hospitalizations, improves resident outcomes, meets regulatory requirements, promotes resident safety. know each resident's baseline, recognize subtle changes early, assess promptly. early interventions improve resident outcomes. During a review of the facility's policy and procedure (P&P) titled, Notification of Changes, dated 2025, the P&P indicated, The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. Circumstances requiring notification include. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: Life-threatening conditions, or Clinical complications. During a review of a professional reference (PR) titled, National Library of Medicine- Chapter 4 Nursing Process, dated 2021, the PR indicated, . Nurses make decisions while providing patient care by using critical thinking and clinical reasoning. Using critical thinking means that nurses take extra steps to maintain patient safety and don't just follow orders. It also means the accuracy of patient information is validated and plans for caring for patients are based on their needs, current clinical practice, and research. The nursing process is a critical thinking model based on a systematic approach to patient-centered care. Nurses use the nursing process to perform clinical reasoning and make clinical judgments when providing patient care.		