

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 04/19/2024
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)		
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review, the facility failed to ensure a physician Informed Consent (the process in which residents are given important information of the possible risk and benefits of psychoactive medications) for the use of psychotropic medication (medication capable of affecting mind, emotions, and behavior) was obtained for one of six sampled residents (Resident 26) when Resident 26 was administered quetiapine fumarate and risperidone (medications used to treat anxiety [intense excessive, and persistent worry and fear about everyday situations]) on 3/26/24 to 4/8/24 and informed consent was not obtained prior to medication administration.</p> <p>These failures resulted in Resident 26 to be administered psychotropic medications and not be fully informed of the risk and benefits and did not have the knowledge to make an informed decision which placed Resident 26 at a potential risk for negative side effects.</p> <p>Findings:</p> <p>During an observation on 4/15/24, at 12:25 p.m. in the dining room, Resident 26 was seated in a geriatric chair (large, padded chair designed to help seniors with limited mobility) appropriately dressed and appeared clean and neat. Resident 26 did not answer any questions asked but instead was observed eating lunch.</p> <p>During a review of Resident 26's Admission Record (AR-document with resident information), dated 4/18/24, the AR indicated, Resident 26 was admitted on [DATE], with diagnosis of dementia (loss of brain function such as memory, thinking, language, judgment, or behavior), with unspecified severity with psychotic disturbance (severe mental disorders that causes abnormal thinking and perceptions [belief or opinion]).</p> <p>During a review of Resident 26's Order Summary Report, dated 4/19/24, the</p> <p>Order Summary indicated, .[QUetiapine Fumarate brand name] Oral Tablet 50 MG [milligram-unit of measurement] Give one tablet by mouth at bedtime related to unspecified dementia . Risperidone 1 MG Give two tablet by mouth at bedtime related to unspecified dementia .</p> <p>During a review of Resident 26's Medication Administration Record (MAR-a document that shows the medications ordered and taken by a resident), dated 3/1/24-3/31/24 and 4/1/24-4/30/24, the MAR indicated, quetiapine fumarate was administered every day starting from 3/26/24 thru 3/31/24 and 4/1/24 thru 4/1/24 thru 4/8/24.</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 26's MAR, dated 3/1/24-3/31/24 and 4/1/24-4/30/24, the MAR indicated, risperidone was administered every day starting from 3/27/24 thru 3/31/24 and 4/1/24 thru 4/1/24 thru 4/8/24.</p> <p>During a concurrent interview and record review with Licensed Vocational Nurse (LVN) 3 on 4/18/24, at 1:40 p.m. Resident 26's order summary for quetiapine and risperidone was reviewed by LVN 3. LVN 3 stated Resident 26 medications were ordered when resident was admitted on [DATE]. LVN 3 stated the informed consents for the quetiapine and risperidone was signed on 4/9/24. LVN 3 stated the quetiapine was administered to Resident 26 daily from 3/26/24-3/31/24 and from 4/1/24- 4/8/24 without a signed informed consent. LVN 3 stated the risperidone was administered to Resident 26 daily from 3/27/24-3/31/24 and from 4/1/24-4/8/24 without a signed informed consent. LVN 3 stated psychotropic medications should have had a signed informed consent prior to administration of the medication. LVN 3 stated licensed nurses were responsible in making sure an informed consents were obtained and explained the risk and benefits to Resident 26 and family prior to administration of medications.</p> <p>During an interview on 4/19/24, at 9:30 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated the admitting nurse was responsible in making sure informed consents were signed prior to administration of a psychotropic medication. MDSC stated psychotropic medication could not be administered without a signed informed consent.</p> <p>During an interview on 4/19/24, at 10:45 a.m. with the Director of Nursing (DON), the DON stated it was the responsibility of the licensed nurse to obtain an informed consent and to make sure there was a signed informed consent prior to administering psychotropic medications. The DON stated Resident 26 was already on quetiapine and risperidone when admitted to the facility. The DON stated Resident 26's family member (FM) did not want to discontinue the medications. The DON stated informed consent were important to explain the risk and benefits of medication to resident and family, so they can decide to take the medication or refused.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Antipsychotic Medication Use dated 7/2022, the P&P indicated, . Residents (and/or resident representative) will be informed of the recommendation, risks, benefits, purpose and potential adverse consequences of antipsychotic medication use . All antipsychotic medications should have informed consent .</p> <p>During review of the facility's policy and procedure (P&P) titled, Use of Psychotropic Medication dated 2/2022, the P&P indicated, . Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions .</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</p> <p>Based on observation, interview, and record review, the facility failed to honor resident's rights for one of eight sampled residents (Resident 12), when Resident 12 was not informed or allowed to decline plan of care. Resident 12 was placed on a low air loss mattress (LAL-enhancing circulation and reducing prolonged pressure in one area) that was contraindicated for fitted sheets and resident's request for fitted sheets was not addressed.</p> <p>This failure resulted in Resident 12 feeling frustrated, ignored, disrespected and physically uncomfortable when she was not allowed to have fitted sheets on her mattress.</p> <p>Findings:</p> <p>During a review of Resident 12's admission record (AR- document with resident demographic and medical diagnosis information) dated 4/17/24, the AR indicated Resident 12 was admitted on [DATE] with diagnosis of Injury of the Cervical (cervical- uppermost region) Spinal Cord, major depressive order (persistently low or depressed mood, decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, agitation, sleep disturbances, or suicidal thoughts), quadriplegia (paralysis of torso and all four limbs), and asthma (a condition in which airways narrow and swell and may produce extra mucus).</p> <p>During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/30/24, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 12 was cognitively intact.</p> <p>During a concurrent observation and interview on 4/15/24 at 12:40 p.m. with Resident 12, in Resident 12's room, Resident 12 was lying on a blue air mattress without any barriers between her upper back and the mattress, a thick multicolored cloth was present from the middle of the resident's back to just below her buttocks. Resident 12 stated, . I bought fitted sheets with deep pockets to fit the air mattress . I was told by a male staff member he would put it on my care plan and get the sheets put on my mattress . Resident 12 began to cry and stated, she felt unsanitary lying on the bare mattress. Resident 12 stated, .I keep requesting for staff to put the sheets on my bed, but they never do . I bought my own sheets so I could have something between me and the mattress . I bought my own sheets with deep pockets so they would fit on to the mattress . I do not understand why they will not put them on . I feel frustrated and ignored .</p> <p>During an observation on 4/16/24 at 4:17 p.m., with Resident 12 in Resident 12's room, Resident 12 was lying on her back, on blue air mattress without a fitted sheet on her bed. Resident 12 appeared to be sleeping.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a concurrent interview and record review on 4/17/24 at 9:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated, the fitted sheet would inhibit the healing property of the mattress. LVN 1 stated he did not educate Resident 12 on how the LAL mattress worked or the reason for not having a fitted sheet. LVN 1 stated the resident should have been educated prior to being placed on the LAL mattress. LVN 1 stated, if the resident was educated and involved in her care, she would not have purchased sheets, she would have had the option to decline being placed on the LAL mattress. LVN 1 stated, Resident 12 was not included in her plan of care.</p> <p>During an interview on 4/17/24 at 2:46 p.m. with the Director of Nursing (DON), the DON stated the resident should have been educated on the reason for placing her on the LAL mattress, how the mattress functions and given the decision to accept or decline being placed on the LAL mattress. DON stated, Resident 12's requests for having fitting sheets placed on the LAL mattress should have been addressed and if the resident no longer wanted to be on the LAL mattress, she should have been given other options for wound prevention. DON stated, Resident 12 was not informed of her right to refuse the mattress. DON stated the facility should have informed her of the right to refuse and honored her rights.</p> <p>During an interview on 4/18/24 at 2:17 p.m. with LVN 3, LVN 3 stated, Resident 12 was placed on the LAL mattress as a preventative measure when a red area on her right buttock was noted. LVN 3 stated, Resident 12 did ask for a fitted sheet but with the low air loss mattress it was contraindicated. LVN 3 stated she did not educate the resident and did not know if anyone else had educated the resident. LVN 3 stated she never discussed alternative options with Resident 12 or informed anyone of Resident 12's concerns. LVN 3 stated Resident 12 should have been involved in the decision to place her on the LAL mattress. LVN 3 stated Resident 12 had the right to decline being placed on the LAL mattress.</p> <p>During a review of the facility's policy and procedure titled, Resident Rights dated 10/2022, indicated . 2. Planning and Implementing care. The resident has the right to be informed of, and participate in, his or her treatment, including b. The right to participate in the development and implementation of his or her person centered-centered plan of care, including but not limited to: i.The right to participate in the planning process, including . the right to request meetings and the right to request revisions to the person-centered plan of care .</p> <p>During a review of facility's document, titled, Low Air Loss Mattress Systems: Your Top Questions Answered undated, the Low Air Loss Mattress Systems: Your Top Questions Answered indicated, .fitted sheets should not be placed over low air loss mattresses because they compress the air cells and restrict air flow. Thin knit or jersey material flat sheets should be used instead. Low air loss mattress covers are specifically designed to allow air flow to pass through and prevent moisture build up. This creates a microclimate between the skin and mattress to keep the user comfortable and prevent skin breakdown. Quilted reusable pads and incontinence briefs will block airflow and trap moisture against the skin .</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608</p> <p>Based on observation, interview and record review, the facility failed to provide a clean and homelike environment for one of 18 sampled residents (Resident 45), when Resident 45's room had chipped, missing and peeling paint on the walls of the bathroom and mirror.</p> <p>This failure had the potential for Resident 45 to not have living space in a homelike environment and possibly feeling depressed.</p> <p>Findings:</p> <p>During a review of the Resident 45's Admission Record (AR- document with resident information), dated 4/17/24, the AR indicated Resident 45 was admitted on [DATE] with diagnosis of malnutrition (not getting enough nutrients for body to thrive), and anxiety disorder (feeling of fear, dread, and uneasiness).</p> <p>During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/30/24, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 45 was cognitively intact.</p> <p>During an interview on 4/15/24 at 12:39 p.m. with Resident 45, in Resident 45's room, Resident 45 stated, the bathroom was dirty, the paint was missing around the sink and paint on the wall was chipped and peeling. Resident 45 stated there was sand in the bottom of the toilet bowl and takes a long time for the bathroom to be cleaned. Resident 45 stated she used her briefs instead of using the bathroom. Resident 45 stated. Using the bathroom is worse than using my brief.</p> <p>During an interview on 4/17/24 at 9:30 a.m. with Licensed Vocational Nurse (LVN) 1, the LVN 1 validated, the chipped and missing paint on and around the bathroom sink in Resident 45's bathroom. LVN stated, this was not a homelike environment. LVN 1 stated, I would not have my bathroom at home in this condition.</p> <p>During an interview on 4/17/24 at 1:55 p.m. with the Director of Nursing (DON), the DON stated the bathroom in Resident 45's bathroom was not kept in a homelike environment.</p> <p>During an interview on 4/18/24 at 12:35 p.m. with Director of Maintenance (DM), the DM stated, the bathroom in Residents 45's bathroom did not provide a homelike environment.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Resident Rights dated 10/2022, the P&P indicated . 8. Safe Environment. The Resident has a right to a safe, clean, comfortable, and homelike environment, .</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set assessment ((MDS -assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of three sampled residents (Resident 57) when Resident 57's functional limitation in range of motion was inaccurately coded on the MDS assessment.</p> <p>This failure had the potential to result in Resident 57's care needs not being met.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/15/24, at 10:20 a.m. in room [ROOM NUMBER], Resident 57 was lying in bed and observed with right sided weakness. Resident 57 stated he was not able to move his right arm and right leg and used his left hand to move his right arm and right leg.</p> <p>During a review of Resident 57's Admission Record (document with resident demographic and medical diagnosis information), dated 4/18/24, indicated Resident 57 was admitted in the facility on 1/30/24 with diagnoses which included cerebral infarction (interrupted blood flow to the brain), muscle weakness and hypertension (high blood pressure).</p> <p>During a review of Resident 57's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment, dated 2/4/24, indicated, the Brief Interview for Mental Status (BIMS) score was 6 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 57 was cognitively impaired in decision making.</p> <p>During an interview on 4/17/24, at 1:49 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 57 was weak on his right side, he needed assistance with his activities of daily living (ADL-related to personal care which includes bathing, dressing, transfers, toilet use). LVN 2 stated Resident 57 was not able to move his right arm and right leg without assistance.</p> <p>During a concurrent interview and record review on 4/17/24, at 3:32 p.m. with Minimum Data Set Coordinator (MDSC), Resident 57's admission MDS assessment dated [DATE], section GG was reviewed by MDSC. The MDSC stated Resident 57 has right sided weakness, he was not able to move his right side without assistance. The MDSC stated Resident 57's functional limitation in range of motion was not coded correctly. The MDSC stated, . It was a mistake, I coded the section wrong . The MDSC stated it was his responsibility to make sure the MDS assessment was accurate.</p> <p>During an interview on 4/19/24, at 11:30 a.m. with the Director of Nursing (DON), the DON stated it was the responsibility of the person completing MDS assessments to ensure their assessments of residents were accurate. The DON stated the MDS assessment should have been accurate, and staff were expected to complete MDS assessments with accuracy.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Conducting an accurate Resident assessment dated ,d+[DATE], the P&P indicated, .Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths and areas of decline .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>40641</p> <p>Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for one of six sampled residents (Resident 57) when Resident 57 was administered apixaban (anticoagulant-blood thinner) medication for atrial fibrillation (an irregular, often rapid heart rate that commonly caused poor blood flow and blood clot formation) and the facility did not initiate a care plan for apixaban.</p> <p>This failure placed Resident 57 at a potential risk for use of anticoagulant needs not met.</p> <p>Findings:</p> <p>During a concurrent observation, and interview on 4/15/24, at 10:20 a.m. in Resident 57's room, Resident 57 was lying down in his bed. Resident 57 stated he was not able to move the right side of his body and needed assistance with his care. Resident 57 stated he wanted to get stronger so he can go home to his ranch but needed someone to take care of him.</p> <p>During a review of Resident 57's Admission Record (document with resident demographic and medical diagnosis information), dated 4/18/24, indicated Resident 57 was admitted in the facility on 1/30/24 with diagnoses which included cerebral infarction (interrupted blood flow to the brain), atrial fibrillation and hypertension (high blood pressure).</p> <p>During a review of Resident 57's clinical record titled Order Summary Report undated, indicated apixaban Oral Tablet 5 MG [blood thinner medication] Give 1 tablet by mouth two times a day related to PERMANENT ATRIAL FIBRILLATION Order date 1/30/24 .</p> <p>During a concurrent interview and record review on 4/17/24, at 2:30 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 57's order summary report was reviewed. LVN 2 stated Resident 57's apixaban was prescribed on 1/30/24. LVN 2 stated she did not find a care plan for Resident 57's anticoagulant use. LVN 2 stated there should have been a care plan developed and it was the charge nurse's responsibility to initiate a care plan.</p> <p>During a concurrent interview and record review on 4/19/24, at 9:15 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 57's care plan was reviewed. The MDSC stated he did not find a care plan for Resident 57's use of anticoagulant medication. The MDSC stated there should have been a care plan to monitor side effects of the anticoagulant medication. The MDSC stated it was the responsibility of the licensed nurses to initiate a care plan and it should be personalized to the need of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/19/24, at 10:15 a.m. with the Director of Nursing (DON), the DON stated charge nurses are responsible in initiating a base line care plan within 24 hours of admission and comprehensive care plan were to be completed within seven days of admission or medication order. The DON stated there should have been a care plan for the use of anticoagulant medication to monitor for bleeding which was one of the side effects of the medication. The DON stated care plans were important because it directed the staff to care for each resident and care plan should be individualized to each resident needs.</p> <p>During a review of facility's policy and procedure titled Care Plans, Comprehensive Person-Centered, dated 3/22, the P&P indicated, . The comprehensive, person-centered care plan is developed within seven (7) days . and no more than 21 days after admission . includes measurable objectives and timeframe; describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation, interview and record review, the facility failed to meet professional standards of practice for three of eight sampled residents (Residents 8, 11 and 57) when:</p> <p>1. Licensed Vocational Nurse (LVN) 2 failed to follow facility's procedure on Proper Inhalation Technique for Metered Dose Inhaler (MDI-small, hand-held device filled with medicine to treat breathing problem) when she administered MDI medication to Residents 11 and 8.</p> <p>This failure had the potential for Residents 8 and 11 to suffer from respiratory infection which could lead to serious health condition.</p> <p>2. Licensed Nurses (LNs) were signing the Electronic Treatment Administration (eTAR- electronic version of standard paper treatment administration record) on Resident 57's order for splint/orthotic device (support to an injured or weakened body part) from 4/1/24- 4/17/24 and not following the treatment order on how the splint/orthotic device was to be applied to Resident 57.</p> <p>This failure had the potential for Resident 57 to not received the full benefits of using the splint/orthotic device.</p> <p>Findings:</p> <p>1. During a medication administration observation on 4/17/24, at 7:23 a.m. in west wing hallway with LVN 2, LVN 2 prepared Resident 11's medications. Resident 11's medications included fluticasone-sameterol (used to treat asthma [long term condition affecting the airways in the lungs]). LVN 2 walked in Resident 11's room, LVN 2 observed sliding the lid of the inhaler to the side exposing the mouthpiece and instructed Resident 11 on how to use the medication inhaler. After medication was administered to Resident 11, LVN slid the lid back to cover the mouthpiece of the inhaler, placed inside the medication box and put it inside the medication cart. LVN 2 did not wash or wipe the inhaler's mouthpiece before and after medication use.</p> <p>During a medication administration observation on 4/17/24, at 7:45 a.m. in west wing hallway with LVN 2, LVN 2 prepared Resident 8's medications. Resident 8's medication included umeclidinium and vilanterol inhalation powder (medication used for chronic obstructive pulmonary disease [COPD-group of diseases that causes airflow blockage and breathing-related problems]). LVN 2 walked into Resident 8's room, slid the lid of the inhaler to the side exposing the mouthpiece and instructed Resident 8 on how to use the medication inhaler. After medication was administered to Resident 8, LVN 2 slid the lid back to cover the mouthpiece of the inhaler and placed inside the medication box and put inside the medication cart. LVN 2 did not wash or wipe the mouthpiece of the inhaler's mouthpiece before and after medication use.</p> <p>During a review of Resident 11's Admission Record (document with resident demographic and medical diagnosis information), dated 4/18/24, indicated Resident 11 was admitted to the facility on [DATE] with diagnoses which included COPD, asthma and heart failure.</p> <p>(continued on next page)</p>		

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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.			
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 11's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment dated [DATE], indicated the Brief Interview for Mental Status (BIMS) score was 15 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 11 was cognitively intact in decision making.</p> <p>During a review of Resident 8's Admission Record, dated 4/18/24, indicated Resident 8 was admitted to the facility on [DATE] with diagnoses which included COPD, hypertension (high blood pressure) and muscle weakness.</p> <p>During a review of Resident 8's Minimum Data Set (MDS-a functional and cognitive abilities assessment) assessment dated [DATE], indicated the Brief Interview for Mental Status (BIMS) score was 6 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 11 was severely impaired in decision making.</p> <p>During an interview on 4/17/24, at 2:15 p.m. with LVN 2, she stated during medication administration of Resident 11 and Resident 8 she did not wash the mouthpiece of Resident 11 and Resident 8's inhaler medication after used. LVN 2 stated she just had skills checked and the instruction was to wash the mouthpiece of inhalers with water after resident use. LVN 2 stated it was an infection control issue. LVN 2 stated residents put their mouth over the mouthpiece and if not washed it could grow bacteria which could cause respiratory infection. LVN 2 stated she should have been more careful and mindful of what she was doing when she was doing her medication pass.</p> <p>During an interview on 4/19/24, at 10:20 a.m. with the Director of Nursing (DON), the DON stated the licensed nurses just had skills checked and the nurses were supposed to wash the mouthpiece of inhalers with water after administration and before placing it back in the box. The DON stated the licensed nurse should have cleaned the inhaler's mouthpiece after resident use as a means of infection prevention. The DON stated not cleaning the inhaler's mouthpiece could harbor bacteria which could lead to serious respiratory disease.</p> <p>During a review of facility's clinical record titled, Medication Administration Observation/Training/Education and Skills Competency, undated, the Medication Administration Observation/Training/Education and Skills Competency indicated, .Proper Inhalation Technique for Metered Dose Inhalers (MDI) . Clean mouthpiece with water and store following manufacturer's recommendation .</p> <p>2. During concurrent observation, interview and record review on 4/17/24, at 2:15 p.m. with LVN 2, Resident 57's order summary report was reviewed. LVN 2 stated Resident 57's least splinting/orthotic device was ordered on 1/31/24. LVN 2 stated she did not know where the splint/orthotic device goes because she did not remember applying the splint/orthotic device to Resident 57 and did not know who was supposed to apply the splint/orthotic device. LVN 2 walked into Resident 57's room and checked where the splint/orthotic device was applied, Resident 57 was lying in bed and was not wearing the splint/orthotic device. LVN 2 reviewed the eTAR (electronic Treatment Administration Record-) dated 4/1/24-4/30/24, LVN 2 stated the eTAR was signed every shift daily from 4/1/24 to 4/17/24. LVN 2 stated she signed the eTAR daily when working not knowing what she was signing. LVN 2 stated she should not have signed the eTAR until she knew the splint/orthotic device was applied.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 57's Admission Record, dated 4/18/24, indicated Resident 57 was admitted to the facility on [DATE] with diagnoses which included cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels), hypertension (high blood pressure) and weakness.</p> <p>During a concurrent interview and record review on 4/18/24, at 3:14 p.m. with LVN 4, Resident 54's eTAR was reviewed. LVN 4 stated she signed Resident 57's eTAR for the application of splint/orthotic device. LVN 4 stated she signed the eTAR because she thought Resident 57 was wearing the sling/orthotic device. LVN 4 stated she should have made sure Resident 57 was wearing the sling/orthotic device prior to signing. LVN 4 stated it was not a good nursing practice not knowing what she was signing.</p> <p>During an interview on 4/19/24, at 10:21 p.m. with the DON, she stated the licensed nurses were responsible in making sure Resident 57's splint was applied before signing eTAR. The DON stated, . It is not acceptable they are just signing without knowing what they are signing . The DON stated the licensed nurses should have checked first then sign. The DON stated it was not an acceptable practice in the facility.</p> <p>During a review of facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion [ROM-how far you can move or stretch a part of your body, such as a joint or a muscle], dated 7/17, the P&P indicated, . 2. Residents with limited range of motion will receive treatment and services to increase and/or prevent further decrease in ROM. 3. Resident with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>40641</p> <p>Based on observation, interview and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted professional principles when Licensed Vocational Nurse (LVN) 6 did not lock her medication cart and went inside a resident room to administer medication.</p> <p>This failure had the potential for residents, staff, and visitors to have access to the unlocked medication cart.</p> <p>Findings:</p> <p>During a review of Resident 12's Admission Record (document with resident demographic and medical diagnosis information), dated 4/18/24, indicated Resident 12 was readmitted in the facility on 9/2/22 with diagnoses which included asthma (difficulty breathing), quadriplegia (weakness of upper and lower body) and heart failure.</p> <p>During a concurrent observation and interview on 4/16/24, at 12:06 a.m. during medication pass observation in south wing hallway. LVN 6 observed preparing medications for Resident 12, after LVN 6 prepared Resident 12, she turned her back on her medication cart, did not locked the medication cart and went inside Resident 12's room and closed the privacy curtain. The medication cart was not within LVN 6 view.</p> <p>During an interview on 19/19/24, at 10: a.m. with the Director of Nursing (DON), the DON stated the facility practice was to make sure to lock the medication cart whenever the medication cart was left unattended. The DON stated medications inside the unlocked medication cart was accessible to residents, staff, and visitors and ingest the medication which could lead to allergic reactions. The DON stated licensed nurses were trained to make sure medication carts were locked when unattended.</p> <p>During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 10/22, the P&P indicated, . All drugs and biologicals will be stored in locked compartments .Only authorized personnel will have access to keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>48424</p> <p>Based on interview and record review the facility failed to hire a qualified Dietary Manager (DM) to carry out the functions of the food and nutrition services for 56 of 61 residents who receive food from the kitchen when the dietary supervisor did not meet the minimum qualifications for the role.</p> <p>This failure had the potential to affect the nutrition status and health of 56 of 61 residents who receive food from the kitchen.</p> <p>Findings:</p> <p>During an interview on 4/16/24 at 10:58 a.m., with the DM, the DM stated she was still in school to become a certified dietary manager. The DM stated she had not yet fully completed her schooling and training. The DM stated she was not certified as of 4/16/24. The DM stated she was unsure if she met the requirements for the dietary manager role.</p> <p>During an interview on 4/18/24 at 2:28 p.m., with the Registered Dietitian (RD), the RD stated the person hired as the dietary manager should have been certified. The RD stated the current DM was not certified for the role. The RD stated it was important to have a certified dietary manager in order to uphold state regulations and to ensure the appropriate rules and regulations were followed in the kitchen.</p> <p>During a review of Dietary Manager job description dated 2023, the job description indicated, . Minimum requirements include one of the following: Certification as a dietary manager, Certification as a food service manager. Has similar national certification for food service management and safety from a national certifying body. Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting .</p> <p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, indicated, . 2-102.11 Demonstration. Based on the risks inherent to the food operation, during inspections and upon request the person in charge shall demonstrate to the regulatory authority knowledge of foodborne disease (illnesses that come from eating food) prevention . and the requirements of this code. the person in charge shall demonstrate this knowledge by . (b) being a certified food protection manager who has shown proficiency of required information through passing a test that is part of an accredited program .</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48424</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe preparation, distribution, and storage practices were followed in the kitchen for 56 of 61 residents in accordance with facility policy and procedure and the US Food Code when:</p> <ol style="list-style-type: none"> 1. The top of the dish washer had crumbs, dust, and was covered in a white residue (material that gets leftover after not being cleaned for some time). 2. The cooking surface of three of seven pans was cracked and peeling. 3. The walk-in freezer had a large icicle (hanging piece of ice that grows as water drips). 4. Oven mitts were torn at the tip and the inside fabric was exposed. <p>These failures had the potential to attract pests, contaminate residents' food, and cause foodborne illnesses to 56 of 61 sampled residents who receive food from the kitchen.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. During a concurrent observation and interview on 4/14/24 at 9:33 a.m., with the Dietary Supervisor (DS) in the kitchen, the top of the dishwasher was covered with dirt, crumbs, and white residue. The DS stated the top of the dishwasher should have been cleaned. The DS stated dirt and crumbs on top of the dishwasher could have fallen on to the dishes and prevented them from being fully cleaned. <p>During a concurrent observation and interview on 4/14/24 at 9:56 a.m., with cook (CK) 1, the CK 1 stated the top of the dish washer was covered with dirt, crumbs, and white residue. CK 1 stated the top of the dish washer should have been cleaned daily. CK 1 stated dishes being washed may have been contaminated by the dirt and crumbs on top of the dish washer.</p> <p>During an interview on 4/17/24 at 3:59 p.m., with the Registered Dietitian (RD), the RD stated the top of the dishwasher should not have had any dirt, crumbs, or white residue on top. The RD stated the white residue build up, food crumbs, and dirt could have led to improper cleaning of the dishes. The RD stated staff should have been trained on cleaning the surface of the dishwasher.</p> <p>During a review of the facility's policy and procedure (P&P) titled Sanitation, dated 10/2022, indicated, . 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements 4. Sanitation inspections will be conducted in the following manner: b. weekly: The dietary manager shall inspect all food services weekly to ensure the areas are clean and comply with sanitation and food service regulations .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, indicated, . 4-602.13 Nonfood-Contact Surfaces. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food .</p> <p>2. During an observation on 4/14/24 at 9:44 a.m., in the kitchen, the cooking surface of three of seven pans was cracked, peeling, and missing.</p> <p>During an interview on 4/18/24 at 2:12 p.m., with the RD, the RD stated the cooking surface of the pans should have been intact. The RD stated the pans should have been replaced because the coating could have gone into a resident's food and caused cross contamination.</p> <p>During an interview on 4/19/24 at 2:28 p.m., with the DS the DS stated the cooking surface of the pans in the kitchen should not have been peeling. The DS stated the coating of the pans could have gotten into the residents' food when they were used to prepare food.</p> <p>During a review of the facility's P&P titled Sanitation, dated 10/2022, indicated, . 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements. 4. Sanitation inspections will be conducted in the following manner: b. weekly: The dietary manager shall inspect all food services weekly to ensure the areas are clean and comply with sanitation and food service regulations .</p> <p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, the Food Code indicated, . 4-601.11 EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces .</p> <p>3. during a concurrent observation and interview on 4/14/24 at 9:56 a.m., with CK 1 in the kitchen, the walk-in freezer had a large icicle hanging inside. CK 1 stated there should not have been an icicle in the freezer. CK 1 stated the icicle could have caused someone to get hurt, there should have been no ice buildup at all.</p> <p>During an interview on 4/18/24 at 2:16 p.m., with the RD, the RD stated the freezer should not have had a large icicle inside. The RD stated the icicle could have been caused by an error in the normal working condition of the inside of the freezer. The RD stated the freezer may not have been operating at its normal recommended capacity and it could have had problems cooling the food stored inside.</p> <p>During an interview on 4/19/23 at 11:34 a.m., with the DS, the DS stated a large icicle should not have been present in the walk-in freezer. The DS stated the icicle could have caused someone to get hurt and it could have indicated a problem with the working condition of the freezer.</p> <p>During a review of the facility's policy and P&P titled Sanitation, dated 10/2022, indicated, . 3. The sanitation program will be provided for inspections to be conducted of the food service areas . 5. Inspections will be conducted but not limited to the following areas: a. Dry Storage b. Freezer c. Refrigerator .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, the Food Code indicated, . Equipment and utensils must be designed and constructed to be durable and capable of retaining their original characteristics so that such items can continue to fulfill their intended purpose for the duration of their life expectancy and to maintain their easy cleanability. If they cannot maintain their original characteristics, they may become difficult to clean, allowing for the harborage of pathogenic microorganisms, insects, and rodents. Equipment and utensils must be designed and constructed so that parts do not break and end up in food as foreign objects or present injury hazards to consumers .</p> <p>4. During a concurrent observation and interview on 4/19/24 at 11:34 a.m., with the DS in the kitchen, oven mitts were torn at the tip and had the interior fabric exposed. The DS stated the oven mitts should have been fully intact because ripped oven mitts could have led to someone getting burned. The DS stated torn oven mitts could have hidden pests and germs.</p> <p>During a concurrent observation and interview on 4/14/24 at 9:56 a.m., with CK1 in the kitchen, the oven mitts were torn at the tip and had the interior fabric exposed. CK 1 stated the oven mitts were torn and ripped. CK 1 stated having torn oven mitts could have caused someone to get burned while handling hot foods and it would have made cleaning the oven mitts more difficult.</p> <p>During an interview on 4/18/24 at 2:12 p.m., with the RD, The RD stated having torn oven mitts could have caused someone to get burned when handling hot items. The RD stated torn oven mitts could hide pathogens (bacteria that make someone sick) and cause contamination (to make dirty or unclean) of food.</p> <p>During a review of the facility's P&P titled Sanitation, dated 10/2022, indicated, . 1. All food service areas shall be kept clean, sanitary, free from litter, rubbish . 2. The department shall establish a sanitation program for food services based on applicable state and federal requirements . 4. Sanitation inspections will be conducted in the following manner: . b. weekly: The dietary manager shall inspect all food servicers weekly to ensure the areas are clean and comply with sanitation and food service regulations .</p> <p>During a review of the Food Code U.S Food and Drug Administration, dated 2022, the Food Code indicated, . 4-601.11 EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641</p> <p>Based on observation and interview, the facility failed to establish and maintain an infection control program to provide a safe, sanitary, and comfortable environment to help prevent infection for one of three sampled residents (Resident 40) when Licensed Vocational Nurse (LVN) 7 failed to sanitize (disinfect) the blood pressure cuff (device used to measure the pressure of blood in the circulatory system), stethoscope (device used to listen to internal sounds of a human body or an animal) after use and did not wash her hands after checking the blood pressure of Resident 40.</p> <p>These failures had the potential to result in cross contamination (bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and transmission of infection between residents.</p> <p>Findings:</p> <p>During a concurrent observation and interview on 4/16/24, at 4:05 p.m. in the east wing hallway by Resident 40's room, LVN 7 was passing medications. LVN 7 checked Resident 40's blood pressure using an arm cuff and a stethoscope and did not sanitize the blood pressure cuff and stethoscope, LVN 7 also was not using disposable gloves. LVN 7 walked out of Resident 40's room and placed the blood pressure cuff and stethoscope on top of medication cart and prepared medications. LVN 7 stated she did not sanitize the blood pressure cuff and stethoscope after she used it on Resident 40 and did not wash her hands before she started preparing medications for Resident 40. LVN 7 stated she did not sanitize the blood pressure cuff and stethoscope after she used it on Resident 40 and did not wash her hands after she checked Resident 40's blood pressure and prior to preparing medications. LVN 7 stated she should have sanitized the blood pressure cuff and stethoscope after each use and before using on another resident. LVN 7 stated she should have washed her hands before preparing Resident 40's medication. LVN 7 stated it was an infection control issue, she could be the carrier of bacteria and spread to other residents.</p> <p>During a review of Resident 40's Admission Record (AR- document containing resident personal information), dated 4/18/24, the AR indicated, Resident 40 was admitted to the facility on [DATE], with diagnoses that included . hypertensive heart disease with heart failure ([long term condition that develops over many years in people with high blood pressure], atherosclerotic heart disease [build up of fats and other substances in the artery wall] .</p> <p>During an interview on 4/19/24, at 11:05 a.m. with the Director of Nursing (DON), the DON stated the licensed nurse should have washed her hands or used alcohol gel and sanitized the blood pressure cuff and stethoscope after she took Resident 40's blood pressure. The DON stated licensed nurse should washed their hands before preparing residents' medications. The DON stated it was infection control issue.</p> <p>During a review of facility's policy and procedure (P&P) titled, Resident-Care Equipment, dated 10/2022, the P&P indicated, . Staff shall follow established infection control principles for cleaning and disinfecting reusable, non critical equipments . Each user is responsible for routine cleaning and disinfection of multi-resident items after each use, particularly before use for another resident . Multiple-resident use equipment shall be cleaned and disinfected after each use .</p> <p>(continued on next page)</p>		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Medication Administration, dated 2/22, the P&P indicated, . Medications are administered by licensed nurses . in a manner to prevent contamination or infection . Wash hands prior to administering medication per facility protocol and product .		