STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055047	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms Care Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51284 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) for three of 14 sampled residents (Resident 28, 37, 41) when: 1. Resident 37's CP did not address Resident 37's preference to maintain an ileostomy (is a surgical procedure where the end of the small intestine (ileum is brought through an opening in the abdomen (stoma) to allow waste to exit the body through a bag instead of the anus) and to manage the associated risk. This failure placed Resident 37 at risk for stoma complications and not to honor residents' choice while ensuring proper care. 2. Resident 41's CP was not developed to address the ongoing medication refusal. This failure had the potential for resident 41 to experience severe and serious medical complications. 3. Resident 28 did not have an individualized care plan for self-harm indicated by pulling dried skin and scabs off her wounds (picking) on her right and left arms and right shoulder causing bleeding and unhealing wounds. This failure placed Resident 28 at an increased risk for wound infection, pain and discomfort. 4. Resident 28's CP was not implemented to provide a toileting schedule (a schedule that instructed Certified Nursing Assistants (CNA)s to assist Residents to the toilet every 2 hours) and adequate supervision and assistance to prevent falls. This Failure resulted in Resident 28 attaining an unwitnessed fall and put Resident 28 at risk for further falls. Findings: (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a review of Resident 37's Admission Record (AR- a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/4/25, the AR indicated, Resident 37 was admitted to the facility on [DATE] with a diagnosis of Protein-calorie Malnutrition (is the state of inadequate intake of food), Supraventricular Tachycardia (a rapid heart rhythm problem where the heart beats too fast), Anxiety (emotion characterized by feelings of unease, worry, or fear), and Ileostomy . During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function assessment, dated 3/8/25, the MDS assessment indicated Resident 37's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 37 was cognitively intact. During a concurrent observation and interview on 4/1/25 at 10:08 a.m. with Resident 37, in Resident 37's room, Resident 37 was observed to have a stoma (surgical opening in the abdomen to allow fecal waste to exit the body into a bag) on the right side of the abdomen, and was uncover. Resident 37 was observed cleaning the stoma with a white washcloth. Resident 37 was observed having a clear large plastic bag filled with white washcloths to the left-hand side on the bed. Resident 37 stated she had an ileostomy. Resident 37 stated the bag over the stoma bothered the stoma area and rather keep the bag off the stoma. Resident 37 stated the nurses could not get the bag to stick on correctly, causing the bag to leak. Resident 37 stated when the bag got too full it bothered her. Resident 37 stated the plastic bag next to her had clean towels inside, her family brought back to the facility after washing the towels. Resident 37 stated she would clean and took care of the stoma using the washcloths to manage the fecal waste coming out of the stoma. During a review of Resident 37's Physician Order (PO), dated 3/1/25, the PO indicated, . Order date: 3/1/25 . Communication Method: Prescriber written . Order Summary: Ileostomy care .every shift . During a review of Resident 37's Electronic Medical Record (EMR), on 4/2/25, the EMR indicated no CP was developed for Resident 37's preferred ileostomy care. During an interview on 4/2/25 at 10:22 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 37 did not like to have the ileostomy bag over the stoma. CNA 2 stated Resident 37 would care for the stoma and the fecal waste with towels her family brought to her. CNA 2 stated Resident 37 did not like the ileostomy bag on because it bothered her, and the bag would get too full too quick. During a review of Resident 37's Hospice Notes (notes created by an individual who is providing care and comfort support to a person terminal ill), on 4/3/25, the Hospice notes indicated, . Reports her ileostomy bag fills very rapidly when she eats anything .she does not want to empty the bag in the middle of a meal .loosing her appetite when she sees her bag fill up (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/2/25 at 2:49 p.m. with Licensed Vocational Nurses (LVN) 3, LVN 3 stated Resident 37 did not have a person centered CP in place for stoma care. LVN 3 stated the CP should be in place indicating resident 37 choice to keep the stoma uncovered. LVN 3 stated the CP was important because it insured everyone who provide care for Resident 37 had the appropriate information needed to provide person centered care. During an interview on 4/3/25 at 11:05 a.m. with the Director of Nursing (DON), the DON stated CP were important for all residents. DON stated her expectation was for the CP to be created on time and updated as needed. During a review of the facility's Policy and Procedure P&P titled, Comprehensive CP, dated 2025, the P&P indicated, .It is the policy of this facility to develop . the comprehensive person-centered CP for each resident . focus on the resident as the locus of control and support the resident .Resident specific interventions that reflect the residents needs and preferences .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions . and when changes are made . 2. During a review of Resident 41's AR, dated 4/3/25, the AR indicated, Resident 41 was admitted to the facility on [DATE] with a diagnosis of Epilepsy [a chronic brain disorder characterized by recurrent seizures(uncontrolled jerking body movements)], Atrial Fibrillation (heart beat irregularly and rapidly), Transient Ischemic Attack (TIA- a medical condition where blood flow to the brain is briefly blocked), and Hypertension (a condition where the force of blood pushing against the artery [A blood vessel that carries blood from the heart to tissues and organs in the body] walls is consistently too high, meaning the heart has to work harder to pump blood. That can lead to serious health problems, such as heart disease, stroke, and kidney failure.) During a review of Resident 41's MDS dated [DATE], the MDS assessment indicated Resident 41's BIMS assessment score was 13 out of 15. The BIMS assessment indicated Resident 41 was cognitively intact. During an interview on 4/1/25 at 4:07 p.m. with Resident 41's Responsible Party (RP), RP stated she was the person of contact for Resident 41. RP stated Resident 41 was admitted into the facility 1/7/25. RP stated Resident had a stroke in the past and began to care for her at home and can no long care for her. RP stated she has not been contacted by the facility to inform her of any changes to Resident 4's condition. During a review of Resident 41's Medication administration Record (MAR- a standardized record that organizes essential information about a patient and their prescribed medications), dated 3/2025, the MAR indicated, .Apixaban (a type of medicine helps prevent harmful blood clots from forming] Oral (by mouth) Tablet 5 milligrams- (MG-a unit of measurement used to measure the dosage of medication] give 1 tablet by mouth two times a day for [for stroke prevention] related atrial fibrillation .start date 1/8/25. The MAR indicated Resident 41 refused the medication twice a day for 24 days out of 31 days. During a review of Resident 41's MAR dated 3/2025, the MAR indicated, Levtiracetam (medication for seizures) 500 MG give two tablets two times a day for seizures .start date 1/8/25. The MAR indicated Resident 41 refused medication twice a day for 24 days out of 31 days in March. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 41's MAR dated 3/2025, the MAR indicated Metoprolol Succiate (medication to lower blood pressure and heartrate) 50 MG 1 tablet by mouth one time a day for high blood pressure .start date 1/8/25, was refused by Resident 41, 27 days out of 31 days in March. During a review of Resident 41's MAR dated 3/2025, the MAR indicated Lisinopril (medication used to lower blood pressure.) .start date 1/8/25 ., 5 MG 1 tablet by mouth one time a day for high blood pressure, was refused by resident 41, 27 days out of 31 days in March. During a concurrent interview and record review on 4/3/25 at 10:21 a.m. with LVN 2 , Resident 41's MAR and CP was review. LVN 2 stated Resident 41's CP for medication refusal and interventions was not created. LVN 2 stated nurses were expected to care plan residents' refusal with person centered interventions. LVN 2 stated after every refusal, the RP and medical doctor should be notified and document the responses. LVN 2 stated a CP should have been created for Resident 41. LVN 2 stated Resident 41 was at risk for health decline refusing medications. During a concurrent interview and record review on 4/3/25 at 11:05 a.m. with the DON, Resident 41's CP and progress (a record of how the residents respond to treatment or services) notes were reviewed. The DON stated she expected the refusal of medication to be documented with Resident 41's reason of refusals, what person-centered education information was provided, with the Residents 47' s' response and to notify the RP, and medical doctor. The [NAME] stated it was important documentation reflected education provided to Resident 41 to ensure she received accurate and ongoing education. The DON stated it was important resident 41's refusals were care planned to ensure interventions were in place to ensure ongoing education of medication importance. During an interview on 4/3/25 at 4:33 p.m. with Medical Doctor (MD), the MD stated he expected nursing staff to provide education on risk and benefits of not taking medication as ordered. The MD stated he expected the nursing staff to contact and inform Resident 41's RP of every refusal. The MD stated he expected nursing staff to document risks and benefit as provided to Resident 41. The MD stated it was important to document the risks and benefits that were explained to Resident 41 to ensure she received education . During a review of the facility's P&P titled, Comprehensive CP, dated 2025, the P&P indicated, .It is the policy of this facility to develop . the comprehensive person-centered CP for each resident . focus on the resident as the locus of control and support the resident .Resident specific interventions that reflect the residents needs and preferences .Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions .and when changes are made . During a review of the facility's P&P titled, Refusal of Treatment/Medication, dated 8/11, the P&P indicated, . Resident refuses treatment .the charge nurse, or DON will interview them to determine what and why they refuse . detailed information relating to the refusal must be entered into the resident's medical record . Documentation .shall include . medication or treatment refused; .response and reason(s) for refusal; . resident was informed to the extent of their ability to understand of the purpose of the treatment and the consequences of not receiving the medication/or treatment . Date and time the physician was notified as well as physicians response . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 4/01/25 at 11:22 a.m. in Resident 28's room, Resident 28 was observed dressed, lying in bed with uncovered wounds on her right and left arms and right shoulder. Resident 28 was observed pulling dried skin and scabs off from her shoulder. Resident 28 stated she picked at her wounds because they itched. Resident 28 stated she was not getting medication for the itching. During a review of Resident 28's AR , dated 4/3/25, the AR indicated Resident 28 was admitted to the facility from an acute care hospital on 12/9/24 with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), muscle weakness, and abnormalities of gait (an unusual walking pattern). During a review of Resident 28's MDS - , dated 2/6/25, the MDS section C indicated Resident 28 had a BIMS score of 11 out of 15 , which suggested Resident 28 was moderately impaired. During an interview on 4/02/25 at 2:33 p.m. with CNA 1, CNA 1 stated Resident 28 picked at her wounds because she was anxious. CNA 1 stated this was a behavior of Resident 28. CNA 1 stated she did not know if Resident 28 was given medication for her wounds. CNA 1 stated she reported Resident 28's behavior and wounds to the nurse. CNA 1 stated Resident 28 had picked at the same wounds, and they were not healing, During a concurrent interview and record review on 4/03/25 at 10:40 a.m. with LVN 1, Resident 28's CP, undated was reviewed. The CP indicated there was no care plan developed and implemented regarding Resident 28 harming herself by picking at her wounds, and no interventions for the care of her wounds. LVN 1 stated Resident 28 was non-compliant with picking at her wounds. LVN 1 stated Resident 28 should have had a CP for her wound care and behavior and should have been put on alert charting for monitoring. LVN 1 stated CPs were important so nurses and CNAs would have continued follow up on resident's goals and would have known if assistance was needed when caring for residents. LVN 1 stated the CPs helped make sure resident's goals and objectives were complete. LVN 1 stated if there was no CP in place, the resident's level of care may not have been met. During a concurrent interview and record review on 4/03/25 at 4:56 p.m. with the Director of Nursing (DON), Resident 28's CP, undated was reviewed. The DON stated there was no care plan in place regarding Resident 28 picking at her wounds. The DON stated she was notified yesterday of Resident 28 picking at her arms and shoulder. The DON stated Resident 28 should have had a care plan for picking at her wounds so staff would have known Resident 28's plan of care and , what interventions were in place to care for Resident 28's wounds. The DON stated the CP helped staff deliver a personalized plan of care and informed staff how to take care of each resident. The DON stated Resident 28's wounds could have gotten worse and had put Resident 28 at risk for infection. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a concurrent observation and interview on 4/01/25 at 11:22 a.m. with Resident 28 in Resident 28's room, Resident 28 was observed dressed, lying in bed. Resident 28 stated she did not know how she was doing. Resident 28 stated she had been at the facility for four to five weeks. Observed fall mats on the right side of Resident 28's bed. Resident 28 stated she had fallen while she had been at the facility. Stated she did not know when she fell . Resident 28 stated her right leg did not work. Resident 28 stated she had gone to the hospital, but did not know if she went to the hospital because of her fall. Resident 28 observed changing position to sit up in bed and move her legs over the side of her bed to attempt to get out of bed. Resident 28 stated she needed to use the restroom. Resident 28 stated she needed help to get to her wheelchair. Observed wheelchair at foot of Resident 28's bed out of reach. During an interview on 4/2/25 at 2:33 p.m. with CNA 1, CNA 1 stated CNAs should have been going to resident rooms every two hours to check on residents and made rounds regularly by going up and down the hallway. CNA 1 stated Resident 28 had a couple of falls. CNA 1 stated she did not know why Resident 28 fell . During a concurrent interview and record review on 4/02/25 at 3:03 p.m. with the Social Services Director (SSD), Resident 28's Interdisciplinary Post Event Note, dated 3/14/25 was reviewed. The Interdisciplinary Post Event Note indicated, . Root cause is she (Resident 28) often calls out for help because she doesn't understand how to use the call light because she is confused . The SSD stated the therapy department was to follow up with Resident 28 to educate on her environmental awareness and use of her call light. During an interview on 4/03/25 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the nurse was responsible for assessing residents for falls. LVN 1 stated if the resident had a fall, the nurse would have assessed the resident after the fall to be sure there were no injuries that would have put the resident at immediate risk. LVN 1 stated the nurse would have assisted the resident to a proper position to be sure the resident was safe, checked the resident's orientation level, called the resident's physician and Responsible Party (RP). LVN 1 stated the nurse would have performed an assessment for a Change of Condition (COC) in the resident's status, and if the resident hit their head, the nurse would have performed neurological (relating to the nervous system) checks for the first two hours. LVN 1 stated neurological checks would have also been performed if the resident's fall was unwitnessed. LVN 1 stated nurses would have put the resident on alert charting after a fall, inform the resident's family, and monitor the resident throughout their shift. The nurse revised the resident's care plan, and the DON sent the reporting to the appropriate facilities. During a concurrent interview and record review on 4/03/25 at 4:56 p.m. with the DON, the DON stated Resident 28 had a fall on 3/14/25 which resulted in no injuries. The DON stated after a resident had a fall, the IDT would review the fall note in the system and go over the root cause of the fall. The DON stated the IDT would come up with therapy or activity recommendations for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/04/25 at 3:24 p.m. with the Director of Staff Development (DSD), Resident 28's Fall Risk Assessment, dated 1/30/25 was reviewed. The Fall Risk Assessment indicated Resident 28 had a fall risk score of 11.0, which was considered a high risk for falls. The DSD stated Resident 28 was a high fall risk resident and staff should have been checking on Resident 28 at least every two hours. Resident 28's CP, undated was reviewed. The CP indicated, . Date Initiated 01/31/25 . Revision on: 02/3/25 . Interventions . anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance . Date Initiated: 01/31/25 . resident to be on a toileting schedule . Date Initiated: 02/03/25 . The DSD stated staff should have checked Resident 28 every two hours for toileting needs. The DSD stated checking residents more frequently than every two hours was important as it provided closer monitoring for residents who were at a higher risk for falls. During a review of the facility's policy and procedure (P&P) titled Comprehensive Care Plans, dated 2025, indicated, . It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs .and meet professional standards of quality . [care and all services are provided according to accepted standards of clinical practice] . resident specific interventions that reflect the resident's needs . 48739

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 48739 Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two of 11 sampled residents (Resident 28 and Resident 57) when: 1. Resident 28 sustained wounds due to continued itching and picking (pulling off dried skin and scabs) from her wounds on her right, left arms and right shoulder and Licensed Vocational Nurses (LVN)s did not notify the physician. This failure resulted in Resident 28 having open, bleeding and unhealing wounds which put Resident 28 at risk for infection and continued discomfort. 2. Resident 57's oxygen therapy (a colorless, odorless, tasteless gas essential to living organisms) was not administered per the physician order. This failure resulted in Resident 57 not receiving his oxygen therapy as ordered which had the potential to result in nasal dryness, shortness of breath, oxygen toxicity, and serious medical condition. Findings: 1. During a review of Resident 28's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/3/25, the AR indicated Resident 28 was admitted to the facility from an acute care hospital on 12/9/24 with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), muscle weakness, and abnormalities of gait (an unusual walking pattern). During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/6/25, the MDS section C indicated Resident 28 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 28 was moderately impaired. During a concurrent interview and record review on 4/03/25 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 28's Progress Notes dated 3/14/25 and 3/21/25 were reviewed. The Progress Note, dated 3/14/25 indicated, . The client was picking at their skin, resulting in open areas with minor bleeding. Bloody tissues were left on their dinner tray . LVN 1 stated there was no documentation of physician notification for Resident 28's continued picking of her wounds. LVN 1 stated the physician should have been notified so he could determine the proper care for Resident 28's wounds and behavior. LVN 1 stated Resident 28 was at risk of infection due to her open wounds. LVN 1 stated the Certified Nursing Assistant (CNA)s should have documented Resident 28's wounds during skin checks and should have notified the nurse of Resident 28 picking at her wounds. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/03/25 at 4:37 p.m. with the Pharmacist Consultant (PC), Resident 28's Order Summary Report, dated 4/3/25 was reviewed. The PC stated some pain medications could have caused itching, but he did not recall being notified Resident 28 had itching. The PC stated he did not evaluate residents but looked at nurses' notes when he did his monthly review. The PC stated he relied on nurses to let him know if there was anything significant going on with a resident. During an interview on 4/04/25 at 3:24 p.m. with the Director of Staff Development (DSD), the DSD stated staff should have checked Resident 28's skin every time they did skin care and during Resident 28's shower. The DSD stated her expectation was staff should have reported any wounds immediately to the charge nurse, so they could have notified the physician and received a treatment plan for Resident 28's wounds and prevented further skin breakdown. The DSD stated it was not okay for CNAs to have observed Resident 28 picking at her wounds and not report it to the charge nurse. During an interview on 4/04/25 at 4:14 p.m. with LVN 1, LVN 1 stated there were no paper log sheets for resident's bathing or showering skin checks. LVN 1 stated CNAs should have let the nurse know if there were any wounds and the nurse would have assessed the resident with the CNA. During a review of the facility policy and procedure (P&P) titled, Wound Treatment Management, dated 2024, indicated . To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders . wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change . in the absence of treatment orders the licensed nurse will notify physician to obtain treatment orders . the effectiveness of treatments will be monitored through ongoing assessment of the wound . During a review of the facility's job description document titled, Licensed Vocational Nurse, undated, the document indicated . Observes for changes in residents' status, notifying the physician . performs wound treatments as per physicians' orders, observes for changes and documents accordingly . performs rounds to ensure resident needs are being met . During a review of the facility's job description document titled, Certified Nursing Assistant, undated, the document indicated . Assists with tracking the condition of the resident's skin. Reports any presence of pressure areas, skin breakdown or skin tears to nurse and supervisor . During a professional reference review obtained from https://www.jamda.com/article/S1525-8610(04)70066-3/abstract titled, Improving Communication Among Attending Physicians, Long-Term Care Facilities, Residents, and Residents' Families, dated March - April 2024, the professional reference review indicated, . effective bidirectional communication (data exchange between two parties) between attending physicians and long-term care facilities is of critical importance to ensure timely, appropriate, and high-quality care that is responsive to resident's needs . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During a review of Resident 57's AR, dated 4/3/25, the AR indicated, Resident 57 was admitted in the facility on 3/12/25, with diagnosis which included .Chronic respiratory failure with hypoxia (occurs when the lungs cannot adequately provide oxygen to the blood, leading to a chronic low oxygen level), heart failure (occurs when the heart can't pump enough blood to meet the body's needs), and pneumonia (a lung infection that inflames the air sacs and can lead to fluid buildup, making it difficult to breathe) . During a review of Resident 57's MDS assessment, dated 3/18/25, the MDS assessment indicated Resident 57's BIMS- assessment score was 9 out of 15 which indicated Resident 57 had moderate cognitive impairment. During a concurrent observation and interview on 4/2/25 at 11:01 a.m. with LVN 1 in Resident 57's room, Resident 57 was observed lying in bed, eyes closed with his nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) in his nose. LVN 1 stated Resident 57 had an order for oxygen therapy 2 LPM (liter per minute- a unit of measurement for the flow rate of oxygen) continuously through the nasal cannula. Resident 57's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents' breath). LVN 1 stated he observed Resident 57's oxygen concentrator on the right side of the bed turned on at 5 LPM. LVN 1 stated Resident 57 had not received oxygen at 2 LPM. LVN 1 stated he was Resident 57's nurse and could not state how long Resident 57 received 5 LPM of oxygen therapy. LVN 1 could not state who increased Resident 57's oxygen therapy. During a concurrent interview and record review on 4/2/25 at 11:05 a.m. with LVN 1, Resident 57's Order Summary Report, dated 4/2/25 was reviewed. LVN 1 stated Resident 57 had an active order for, .Oxygen at 2 LPM via nasal cannula every shift . LVN 1 stated Resident 57 had not received oxygen at 2 LPM. LVN 1 stated Resident 57 had not received oxygen therapy as per the physician order. LVN 1 stated it was important to follow all physician orders as prescribed. LVN 1 stated Resident 57 was at risk for nasal dryness and increased need for oxygen therapy requirements. During a concurrent interview and record review on 4/2/25 at 11:09 a.m. with Respiratory Therapist (RT) 1, outside of Resident 57's room, RT 1 stated Resident 57 had chronic respiratory failure and required continuous oxygen therapy at 2 LPM . RT 1 stated Resident 57 was not in any respiratory distress and his oxygen therapy should not have been increased. RT 1 stated oxygen was a medication, and all medication orders were expected to be followed. RT 1 stated Resident 57 had not received his oxygen therapy as prescribed by the physician. RT 1 stated she was Resident 57's RT and could not state how long Resident 57 received 5 LPM of oxygen therapy. RT 1 could not state who increased Resident 57's oxygen therapy. During a concurrent interview and record review on 4/3/25 at 4:32 p.m. with the Director of Nursing (DON), the DON stated oxygen therapy was a physician's order and was considered a medication. The DON stated all physician orders and medications must be administered as prescribed. The DON stated Resident 57's oxygen therapy was not administered as prescribed. The DON stated only physician's, Registered Nurses (RN), LVN's, and RT's were allowed to adjust the oxygen concentrator. The DON stated Resident 57 was at risk for shortness or breath with increased oxygen administration and oxygen toxicity. During a review of Resident 57's Order Summary Report, dated 4/3/25, the Order Summary Report indicated, Resident 57 had an active order for oxygen .at 2 Liters/Min via nasal cannula every shift . (continued on next page)

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	055047	A. Building B. Wing	04/04/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, undated, the P&P indicated, .Oxygen is administered to residents who need it, consistent with professional standards of practice .oxygen is administered under orders of a physician .personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists . During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Ensure that the six rights of medication administration are followed .right drug .right dosage . During a review of the facility's job description document titled, Licensed Vocational Nurse, undated, the document indicated, .Transcribes physician orders .and carries out orders as written .prepares and administers medications as per physicians' orders . During a review of the facility's job description document titled, Respiratory Therapist, undated, the document indicated, .Plans, develops, organizes, implements, evaluates, and directs the execution of respiratory care services in accordance with physician's orders . During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . 51059 2. During a review of Resident 57's AR, dated 4/3/25, the AR indicated, Resident 57 was admitted in the facility on 3/12/25, with diagnosis which included .Chronic respiratory failure with hypoxia (occurs when the lungs cannot adequately provide oxygen to the blood, leading to a chronic low oxygen level), heart failure (occurs when the heart can't pump enough blood to meet the body's needs), and pneumonia (a lung infection that inflames the air sacs and can lead to fluid buildup, making it difficult to breathe) . During a review of Resident 57's MDS assessment, dated 3/18/25, the MDS assessment indicated Resident 57's BIMS- assessment score was 9 out of 15 which indicated Resident 57 had moderate cognitive impairment. During a concurrent observation and interview on 4/2/25 at 11:01 a.m. with LVN 1 in Resident 57's room, Resident 57 was observed lying in bed, eyes closed with his nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) in his nose. LVN 1 stated Resident 57 had an order for oxygen therapy 2 LPM (liter per minute- a unit of measurement for the flow rate of oxygen) continuously through the nasal cannula. Resident 57's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents' breath). LVN 1 stated he observed Resident 57's oxygen concentrator on the right side of the bed turned on at 5 LPM . LVN 1 stated Resident 57 had not received oxygen at 2 LPM. LVN 1 stated he was Resident 57's nurse and could not state how long Resident 57 received 5 LPM of oxygen therapy. LVN 1 could not state who increased Resident 57's oxygen therapy. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/2/25 at 11:05 a.m. with LVN 1, Resident 57's Order Summary Report, dated 4/2/25 was reviewed. LVN 1 stated Resident 57 had an active order for, .Oxygen at 2 LPM via nasal cannula every shift . LVN 1 stated Resident 57 had not received oxygen at 2 LPM. LVN 1 stated Resident 57 had not received oxygen therapy as per the physician order. LVN 1 stated it was important to follow all physician orders as prescribed. LVN 1 stated Resident 57 was at risk for nasal dryness and increased need for oxygen therapy requirements. During a concurrent interview and record review on 4/2/25 at 11:09 a.m. with Respiratory Therapist (RT) 1, outside of Resident 57's room, a picture of Resident 57's oxygen concentrator taken by the surveyor, dated 4/2/25 was reviewed. RT 1 stated the picture of the oxygen concentrator was Resident 57's RT 1 stated Resident 57's oxygen concentrator was on 5 LPM. RT 1 stated Resident 57 had chronic respiratory failure and required continuous oxygen therapy at 2 LPM . RT 1 stated she observed Resident 57 from the door way, outside Resident 57's room. RT 1 stated Resident 57 was not in respiratory distress and his oxygen therapy should not have been increased. RT 1 stated oxygen was a medication, and all medication orders were expected to be followed. RT 1 stated Resident 57 had not received his oxygen therapy as prescribed by the physician. RT 1 stated she was Resident 57's RT and could not state how long Resident 57 received 5 LPM of oxygen therapy. RT 1 could not state who increased Resident 57's oxygen therapy. During a concurrent interview and record review on 4/3/25 at 4:32 p.m. with the Director of Nursing (DON), a picture of Resident 57's oxygen concentrator taken by the surveyor, dated 4/2/25 was reviewed. The DON stated Resident 57's oxygen concentrator was turned on to 5 LPM and not the ordered 2 LPM. The DON stated oxygen therapy was a physician's order and was considered a medication. The DON stated all physician orders and medications must be administered as prescribed. The DON stated Resident 57's oxygen therapy was not administered as prescribed. The DON stated only physician's, Registered Nurses (RN), LVN's, and RT's were allowed to adjust the oxygen concentrator. The DON stated Resident 57 was at risk for shortness or breath with increased oxygen administration and oxygen toxicity. During a review of Resident 57's Order Summary Report, dated 4/3/25, the Order Summary Report indicated, Resident 57 had an active order for oxygen .at 2 Liters/Min via nasal cannula every shift . During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, undated, the P&P indicated, .Oxygen is administered to residents who need it, consistent with professional standards of practice .oxygen is administered under orders of a physician .personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists . During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Ensure that the six rights of medication administration are followed .right drug .right dosage . During a review of the facility's job description document titled, Licensed Vocational Nurse, undated, the document indicated, .Transcribes physician orders .and carries out orders as written .prepares and administers medications as per physicians' orders . During a review of the facility's job description document titled, Respiratory Therapist, undated, the document indicated, .Plans, develops, organizes, implements, evaluates, and directs the execution of respiratory care services in accordance with physician's orders . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51059 Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 261) was provided activities that met his preferences and interests to support mental and psychosocial well-being when Resident 261's developed activities did not match his interests or preference to write, draw or color. This failure had the potential for Resident 261 to result in isolation and decreased engagement in activities. Findings: During a review of Resident 261's Admission Record (AR- a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/3/25, the AR indicated, Resident 261 was admitted to the facility on [DATE], with diagnosis which included, .Convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement) .hypertension (high blood pressure) and muscle weakness . During a review of Resident 261's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) assessment, dated 2/20/25, the MDS assessment indicated Resident 261's Brief Interview for Mental Status (BIMS- a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) assessment score was 15 out of 15 which indicated Resident 261 had no cognitive impairment. During a review of Resident 261's Activities- Initial Review, dated 8/19/24, the Activities- Initial Review indicated, .likes .writing . During an interview on 4/1/25 at 10:00 a.m. with Resident 261, Resident 261 stated he did not participate in activities. Resident 261 stated the activities at the facility did not interest him. Resident 261 stated he liked to draw, color and write. Resident 261 stated he would enjoy participating in group activities if the facility had more drawing, writing and coloring activities. During a concurrent interview and record review on 4/3/25 at 11:46 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 261's Care Plan, dated 4/3/25 was reviewed. LVN 1 stated he was familiar with Resident 261. LVN 1 stated Resident 261 enjoyed drawing and coloring activities. LVN 1 stated Resident 261 was often observed coloring and drawing in his room. LVN 1 stated Resident 261's care plan did not reflect his preference and interest to draw, color or write. LVN 1 could not locate any progress activities notes in Resident 261's medical chart to reflect participation in coloring, drawing or writing in his room. LVN 1 stated Resident 261's care plan should have been updated to reflect his preferences and interests. LVN 1 stated he would expect activity progress notes to reflect Resident 261's participation or refusal to participate in activities independently. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/25 at 11:56 a.m. with the Activities Director (AD) 2, Resident 261's care plan, dated 4/3/25 was reviewed. AD 2 stated she was responsible to ensure activities met resident interests and preferences. AD 2 stated she was responsible to provide activities to residents within their room if they did not want to participate in the activity room. AD 2 stated she was responsible to update, review and revise all care plan and notes for resident participation in activities. AD 2 stated Resident 261's care plan did not reflect his preference and interest to draw, color or write. AD 2 stated it was important Resident 261's care plan and notes reflected his preferences and interests so all staff members could implement his choice of activities. AD 2 stated she participated in resident council on 2/19/25 and there was a request in the resident council meeting for more painting and coloring activities. AD 2 stated she did not add painting or coloring activities to the March calendar in response to resident council. AD 2 stated she added Residents Choice every Friday to the March activity calendar in response to resident council. AD 2 stated Resident Choice allowed each resident to choose which activity they wanted to participate in. AD 2 stated residents would need to ask for coloring, drawing or writing material if they chose those activities on Resident Choice days. During an interview on 4/3/25 at 4:32 p.m. with the Director of Nursing (DON), the DON stated she expected all preferences and interests to be reflected and implemented in care plans. The DON stated she expected all suggested activities in resident council to be implemented by the activities department. The DON stated it was important to implement activities that interested each resident to promote engagement. The DON stated Resident 261 was at risk for isolation and decreased engagement if his activity interests were not implemented. During a record review of Resident 261's Care Plan, dated 4/3/25, the Care Plan indicated, Resident 261 enjoyed watching television independently in his room. The Care Plan did not reflect Resident 261's interest to draw, color or write. During a review of the facility's document titled, In Room Resident Council, dated 2/19/25, the document indicated, .Issues, concerns or comments .paint rocks .more paintings and coloring pages .paint or decorate . During a review of the facility's document titled, Department Response Form, Department Activities, dated 2/19/25, the document indicated, .AD to add past activities to new coming months calendars . The document was signed as reviewed by the AD 2. During a review of the facility's document titled, Resident Council Minutes, dated 3/19/25, the document indicated, .New activities suggestions .more painting color .painting .arts and crafts . The document was signed as reviewed by the AD 2. During a review of the facility's activity calendar titled, January 2025, dated 1/2025, the document indicated, five days for coloring and four days for arts and crafts. During a review of the facility's activity calendar titled, February 2025, dated 2/2025, the document indicated, four days for arts and crafts and four days for residents' choice. During a review of the facility's activity calendar titled, March 2025, dated 3/2025, the document indicated, five days for arts and crafts and four days for residents' choice. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's activity calendar titled, April 2025, dated 3/2025, the document indicated, four days for arts and crafts and four days for residents choice. During a review of the facility's job description document titled, Activities Director, undated, the document indicated, .Assists in planning, organizing, implementing, and evaluating all recreational, social, intellectual, emotional and spiritual programs, in accordance with facility policy, the resident's care plan, and as directed by supervisors . During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, undated, the P&P indicated, .Resident specific interventions that reflect the resident's needs and preferences .the comprehensive care plan will be prepared by an interdisciplinary team, that includes .activities director/staff . During a review of the facility's P&P titled, Resident Self Determination and Participation (Schedules), undated, the P&P indicated, .According to federal regulations, the resident has the right to .choose activities . consistent with his or her interests, assessments, and plans of care .activity staff should assist the resident to engage in meaningful activity during the day, according to preference .activity staff should assist in obtaining needed supplies or equipment, to assist the resident in developing a lifestyle in the facility similar to that at home (examples may include .writing paper and pencils .) .plans of care should be considerate of resident preferences and routines, to help avoid problem behaviors .activity staff should assist the resident in scheduling of daily activities so that all interests can be accommodated . During a review of the facility's P&P titled, Activities, undated, the P&P indicated, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental and psychosocial well-being. Activities will encourage both independence and interaction with he community . activities will be designed with the intent to .create opportunities for each resident to have a meaningful life .promote or enhance emotional health .promote self-esteem, dignity, pleasure, comfort .independence .reflect resident's interests .reflect choices of the residents .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 51059 Based on observation, interview and record review, the facility failed to ensure daily nurse staffing information contained all required information when the total number of hours and actual hours worked by Registered Nurse (RN)s, Licensed Vocational Nurse (LVN) s, Licensed Practical Nurse (LPN)s, and Certified Nursing Assistant (CNA)s were not separated, and was not posted in a prominent readily accessible location to 60 out of 60 residents and visitors. This failure resulted in restricted public access to posted nurse staffing information for 60 out of 60 residents admitted within the facility which had the potential to result in residents not knowing how many direct care hours were provided daily. Findings: During a concurrent interview and record review on 4/3/25 at 1:54 p.m. with the Director of Staff Development (DSD), the facility's document titled Daily Nurse Staffing , dated 4/3/25 was reviewed. The facility's daily nurse staffing document indicated, .Total Hands on PPD (Per Patient Day) . 3.7 [hours] .Total Hours 222 [hours] .Divided by total census 60 . The DSD could not state or locate the total number and actual hours worked by RNs, LVNs/LPNs, or CNAs on the daily nurse staffing document. The DSD stated she was responsible to calculate unlicensed nursing staff total number and actual hours worked by CNAs. The DSD stated the Director of Nursing (DON) was responsible to calculate licensed nursing staff total number and actual hours worked by the LVNs or LPNs and RNs. The DSD stated she was responsible to post daily nurse staffing information with all required information. During a concurrent observation and interview on 4/3/25 at 2:15 p.m. with the DSD at the nursing station, the facility's daily nurse staffing document was observed posted behind the nursing station to the right of the facility's sink. At the entrance of the nursing station a sign indicated, Staff members only beyond this point. Thank you. The DSD stated residents and visitors were not allowed behind the nursing station. The DSD stated residents and visitors could not readily access or view the daily nurse staffing information behind the nursing station. The DSD stated residents and visitors had to ask for the daily nurse staffing information. The DSD stated the daily nurse staffing information should be posted in a location easily accessed and viewable to all 60 residents and visitors. The DSD stated unlicensed and licensed nursing staff hours should be separated. The DSD stated residents and visitors had a right to view and access the posted nurse staffing information without assistance. The DSD stated residents and visitors had a right to know which staff members were working and how many direct care hours were provided for each resident every day. (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent interview and record review on 4/3/25 at 4:32 p.m. with the DON, the facility's document titled Daily Nurse Staffing (DNS), dated 4/3/25 was reviewed. The DON could not state or locate the total number and actual hours worked by RNs, LVNs/LPNs, or CNAs on the DNS document. The DON stated the facility's DNS document was posted behind the nursing station. The DON stated the facility's DNS document was not readily accessible to all residents and visitors. The DON stated it was important to have the total number and actual hours worked by RNs, LVNs/LPNs, and CNAs. The DON stated it was important residents and visitors had access to the facility's daily nurse staffing document with all required information so they could view what staff was on shift, how many staff were available and how many licensed/ unlicensed direct care hours were provided to care for each resident on daily basis. During a concurrent interview and record review on 4/3/25 at 4:57 p.m. with the Administrator (ADM), the facility's document titled DNS, dated 4/3/25 was reviewed. The ADM could not state or locate the total number and actual hours worked by RNs, LVNs/LPNs, or CNAs on the DNS document. The ADM stated, 99% of the time it [the facility's DNS document] is posted behind the nursing station. The ADM stated the document was not easily accessible to all residents or visitors when the document was behind the nursing station. The ADM stated residents and visitors had a right to view and know nurse staffing information with all required information. The ADM stated the facility did not have a policy or procedure for posted daily nurse staffing information or requirements. The ADM stated he expected the facility to follow state regulations for posted nurse staffing information. During a review of the facility's document titled DNS, dated 3/27/25, 3/28/25, 3/29/25, 3/30/25, 3/31/25, 4/1/25, 4/2/25, and 4/3/25 the documents were not separated by the total number and actual hours worked by RNs, LVNs/LPNs and CNAs. The document combined all unlicensed and licensed nursing hands on care provided to residents into, Total Hands on PPD. During a review of the facility's job description document titled, Director of Nursing, undated, the job description indicated, .Oversees nursing schedules to ensure resident needs, regulatory and budget standards are met . During a review of the facility's job description document titled, Administrator, undated, the job description indicated, Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51271 Based on observation, interview and record review the facility failed to ensure the Registered Dietitian (RD) offered adequate consultation to support food and nutrition services, residents' assessments and the development of individualized care plans for one of six sampled residents (Resident 39), when RD did not follow up with weight changes for Resident 39. This failure had the potential to cause reduced quality of life and risk of weight loss, dehydration and delayed wound healing. Findings: During an interview on 4/1/25 at 9:22 a.m. with the Certified Dietary Manager (CDM), the CDM stated the Registered Dietitian (RD) was not onsite. CDM stated RD typically worked on Saturdays. During an interview on 4/2/25 at 9:11 a.m. with Kitchen Staff (KS) 1, KS 1 stated the RD did not do staff training; it was done by the CDM. During an interview on 4/2/25 at 2:51p.m. with the CDM, the CDM stated she was responsible for the day -to-day operations, ordering, and tray line audits. The CDM stated the RD conducted sanitation audits. The CDM stated for new admissions, she interviewed the residents and completed the nutritional screening, resident preferences, tray cards and verified supplements. The CDM stated the RD's working hours were not consistent, as he worked at another facility. During an interview on 4/2/25 at 3:01 p.m. with the RD, the RD stated he worked around five to seven hours a week and did not have set scheduled days. The RD stated he came in after he finished work at his other job. The RD stated he was responsible for overseeing the kitchen, completing the administrator checklist, checking temperature logs and monitoring weight changes and assessments. The RD stated he did not provide any trainings or in-services; all in-services were done by the CDM. The RD stated he did not typically encounter the kitchen staff since his hours varied so much. During an interview on 4/3/25 at 9:29 a.m. with the CDM, the CDM stated the Director of Nursing (DON) would email her and the RD a list of residents triggered for weight changes. The CDM stated they had weekly Interdisciplinary Team (IDT) meetings with the DON, activities, social services and therapy. The CDM stated the RD did not attend those meetings. During an interview on 4/3/25 at 4:18 p.m. with the Administrator (ADM), the ADM stated the expectation for the dietitian was to be at the facility six to eight hours a week. The ADM stated he was expected to complete the sanitation reports and oversee the CDM. The ADM stated the RD was supposed to communicate with the DON about clinical issues related to resident weights. The ADM stated he wanted RD to work more hours to fulfill his job duties. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 4/3/25 at 4:56 p.m. with the DON, progress note dated 3/17/25 was reviewed. The progress note indicated, Resident 39 had a five-pound weight loss in a week. The DON stated she did not know if RD was made aware of the weight loss for Resident 39. The DON stated the RD came in on Saturdays. The DON stated the RD only wrote one note in Resident 39's chart since January and no follow up notes since then. The DON stated the RD was not involved nor present in IDT meetings. The DON stated the RD probably should be involved in residents nutritional needs, because he was the one the facility turned to for guidance to ensure the residents received adequate calories. The DON stated they relied on the RD for all recommendations. The DON stated it would be nice to have the RD at the facility more often. The DON stated she emailed the RD and CDM the weekly weights that were triggered for weight gain or loss. The DON stated the RD was to send his recommendation. The DON stated it was his job to oversee the resident's weights. The DON stated in February and March the RD did not complete the Dietitian Nutritional Recommendations for Resident 39 even though Resident 39 was still triggered for weight change. The DON stated the Dietitian Nutritional Recommendations should have been done weekly until the resident was no longer triggered for weight changes. The DON stated she did not know if the RD was aware of Resident 39's weight fluctuation. The DON stated she did not know if the RD was able to fulfill his job duties due to the time spent at the facility. The DON stated she believed RD could have been seeing more residents and providing more dietary recommendations, if he come to the facility more often. The DON stated the RD did not create care plan for residents. The DON stated there were gaps in the recommendations he sent for February and March. During a review of the Offer Letter-Registered Dietitian dated 10/20/23, indicated the RD accepted the position as the Registered Dietitian. During a review of Dietitian Job Description dated 2023, indicated, the RD .The RD assessed and monitored the resident's nutritional status and provided recommendations to clinical/medical staff . Developed and updated nutritional care plans as needed .observed resident meal service to ensure diets were correct and modifications were followed .worked with other members of the interdisciplinary team to ensure that modified texture or therapeutic diets were in compliance with the residents medical condition .Conducted audits of relevant nutritional care on a routine basis .monitored residents for weight changes, nutrition support, and skin breakdown and made recommendations as needed . During a review of Employee Timecards dated 10/2024 through 3/2025 the RD worked these many hours per month: October 2024- 18.7 hours November 2024- 8 hours December 2024- 11 hours January 2025- 34.5 hours February 2025- 9.8 hours March 2025- 16.5 hours (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the State requirements professional reference titled, Title 22 California Code of Regulations (CCR) Section S72351 Dietic Service Staff,, indicated, . (a) A registered dietitian shall be employed on a full-time, part-time or consulting basis. Part-time or consultant services shall be provided on the premises at appropriate times on a regularly scheduled basis and of sufficient duration and frequency to provide continuing liaison with medical and nursing staffs, advice to the administrator, patient counseling, guidance to the supervisor and staff of the dietetic service, approval of all menus and participation in development or revision of dietetic policies and procedures and in planning and conducting in-service education programs. During the review of Resident 39's Admission Record (AR- a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/15/23, the AR indicated Resident 39 was admitted to the facility on [DATE] with the diagnosis of: hemiplegia (total loss of movement of the arm, leg and trunk on the same side of the body), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and cerebrovascular accident (CVA-stroke, loss of blood flow to part of the brain). During a review of Resident 39's Minimum Data Set (MDS-a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/20/25, the MDS section C indicated Resident 39 had a Brief Interview for Mental Status (BIMS- a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 39 had severe cognitive impairment. During a review of Care Plan Report dated 1/24/25, indicated of all Resident 39's active care plans, none of them were created by the RD. During a review of Dietitian Nutritional Recommendations dated 1/9/25, indicated Resident 39 was flagged for having a five percent change in their weight. The RD reviewed the case and recommended a decrease in the formula (is a diet designed to meet the needs of patients who require full or partial tube feeding). During a review of a Progress Note dated 1/12/25, indicated the RD made a formula change to address Resident 39's weight gain of sixteen pounds over six months. The RD recommended decreasing the Resident 39's formula from eight cans to seven per day. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Revised 2024 Scope and Standards of Practice for Registered Dietitian Nutritionist (RDN) from the Commission on Dietetic Registration the credentialing agency for the Academy of Nutrition and Dietetics, indicated, RDNs (RDs) are the most qualified to provide Medical Nutrition Therapy (MNT), a cost-effective, essential component of comprehensive nutrition care. It indicated RDs in clinical practice provide person centered nutrition care and MNT use the Nutrition Care Process (NCP- is a systematic problem-solving method that credentialed nutrition and dietetics practitioners use to critically think and make decisions when providing MNT or to address nutrition-related problems and provide safe and effective quality nutrition care. The NCP consists of four distinct, interrelated steps: Nutrition Assessment and Reassessment, Nutrition Diagnosis, Nutrition Intervention, and Nutrition Monitoring and Evaluation). It indicated in Standard 7 (seven) providing person-/population-centered nutrition care, the registered dietitian nutritionist (RDN) conducts nutrition care process and workflow elements to identify and address nutrition-related problems which a RDN is responsible for treating. It indicated the RD: .7.2 Conducts nutrition assessment . 7.2.5 Obtains and assesses findings from nutrition-focused physical exam (NFPE) .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on interview and record review, the facility failed to ensure accurate and complete medical records in accordance with professional standards of practices were maintained for one of seven sampled residents (Resident 28), when the Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) was not accurate and complete. This failure had the potential for Resident 28's decisions regarding treatment options and end of life wishes to not be honored. Findings: During a concurrent observation and interview on [DATE] at 11:22 a.m. with Resident 28 in Resident 28's room, Resident 28 was observed dressed in bed. Resident 28 could not state how she was doing. Resident 28 stated she had been at the facility for four to five weeks. During a review of Resident 28's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 28 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), muscle weakness, and abnormalities of gait (an unusual walking pattern). During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 28 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of ,d+[DATE]) score of 11 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact), which suggested Resident 28 was moderately impaired. During a concurrent interview and record review on [DATE] at 10:40 a.m. with Licensed Vocational Nurse (LVN) 1 Resident 28's POLST undated was reviewed. The POLST indicated, the section for date the form prepared was undated, signature of patient or legally recognized decisionmaker which included: name, signature, mailing address, phone number, relationship, and date were not filled in, signed, or dated. LVN 1 stated the resident or responsible party (RP)'s signature section was not completed. LVN 1 stated Resident 28's POLST was not complete. LVN 1 stated Resident 28, or her RP should have signed and dated the POLST form. LVN 1 stated the resident's signature verified the POLST was discussed with the resident, and she agreed with the POLST orders. LVN 1 stated the Medical Records department was responsible for making sure resident's forms were complete before they were scanned into the resident's records. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 4:56 p.m. with the Director of Nursing (DON), Resident 28's POLST undated was reviewed. The POLST indicated sections of the Date Prepared and Signature of Patient or Legally Recognized Decisionmaker were not filled in. The DON stated the resident or RP's signature should have been completed. The DON stated her expectation was for residents' POLSTs to be completed on admission. The DON stated the POLST was considered a physician order, and the physician should sign and date the POLST form. DON stated the nurse would have followed up with the incomplete POLST since it had the physician's signature. The DON stated Resident 28's POLST was not complete due to no resident or RP signature. The DON stated before the POLST was scanned into Resident 28's chart, Medical Records Clerk should have made sure it was complete. The DON stated if Resident 28's POLST was not complete, they should have given it back to the Social Services Director (SSD) to have it signed by Resident 28 or her RP. The DON stated the POLST was important so staff would know what to do if there was a change in the resident's condition, or if the resident needed a higher level of care and needed to be transferred to the hospital. The DON stated if a resident had no pulse, the POLST let staff know what emergency care they could do such as give cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) or place a G-tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach for people with swallowing problems). The DON stated if the resident's POLST was not complete, there was a risk for the resident's end-of-life wishes for treatment of not being met. During a review of the facility job description document titled, Medical Records Clerk, undated, the document indicated, . Ensures incomplete records/charts are returned to appropriate department or personnel for corrections . ensures resident records are properly completed, assembled, coded, etc., before filing . During a review of the facility job description document titled, Social Services Director, undated, the document indicated, . The Social Services Director will oversee the process of Advance Care Planning for each resident upon admission . The Director will ensure that staff members are made aware of the resident's code status and end-of-life wishes and will assist with informing and educating residents and their representatives about health care options and ramifications . Policy and Procedure for Medical Records/Accuracy of Resident Records was requested multiple times and not receives.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51284 Based on observation, interview, and record review the facility failed to ensure an infection prevention and control program was maintained for 7 of 14 sampled residents (Resident 4, 9, 10, 22, 48, 50, and 261), when: 1. Licensed Vocational Nurse (LVN) 1 and LVN 2 did not perform hand hygiene [cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based rub (ABHR)] between Resident 10, 22, 48, 50, and 261 during medication administration. This failure had increased risk of cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effects) and the spread of infection. 2. Resident 4's oxygen nasal cannula (O2 NC- a tube that directs oxygen into the nose) tubing was observed not in a protective bag on top of the oxygen concentrator (medical device that supplies oxygen-enriched air to help people breathe easier). This failure placed Resident 4 at risk for cross contamination which could result in infection and illness. 3. Certified Nursing Assistant (CNA) 4 did not perform hand hygiene after leaving a resident room and before entering and exiting Resident 9's room. This failure had the potential to cause cross contamination and the spread of harmful pathogens (tiny germs like bacteria or viruses) from one resident 's environment to another, leading to potential infections. Findings: 1. During an observation of medication administration on 4/2/25 at 11:31 a.m. LVN 1 and LVN 2 were observed administering afternoon medications to Resident 10, 22, 48, 50, and 261. LVN 1 and LVN 2 did not perform hand hygiene between administering the medications to residents. During a review of Resident 10's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive[mental processes], physical functional level assessment), dated 12/18/24, the MDS section C indicated Resident 10's Brief Interview for Mental Status (BIMS- a test given by medical professionals to determine cognitive(involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score was 15 out of 15 (0-6 severe cognitive impairment, 7-12 moderately impaired, 13-15 cognitively intact) which indicated Resident 10 was cognitively intact. During a review of Resident 22's MDS assessment dated [DATE], the MDS assessment indicated Resident 22's BIMS assessment score was 12 out of 15 which indicated Resident 22 had moderately impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's MDS assessment dated [DATE], the MDS assessment indicated Resident 48's BIMS assessment score was 00 out of 15 which indicated Resident 22 had severe cognitive impairment. During a review of Resident 50's MDS assessment dated [DATE], the MDS assessment indicated Resident 50's BIMS assessment score was 13 out of 15 which indicated Resident 22 was cognitively intact. During a review of Resident 261's MDS assessment dated [DATE], the MDS assessment indicated Resident 261's BIMS assessment score was 15 out of 15 which indicated Resident 22 was cognitively intact. During a concurrent observation and interview on 4/2/25 at 11:31 a.m. with Licensed Vocational Nurse (LVN) 1 in the south hall, during afternoon medication administration. LVN 1 was observed administering medications to Resident 10, 22 and 261 without performing hand hygiene. LVN 1 stated hand sanitizer should have used before and after entering the residents' rooms. LVN 1 stated it was important to wash hands between residents during medication pass to reduce the risk of infection for other residents. During an observation on 4/2/25 at 11:57 a.m. LVN 2, was observed in the East Hall exiting Resident 48's room and entering Resident 50's room without performing hand hygiene during afternoon medication administration. During an interview on 4/2/25 at 11:57 a.m. with LVN 2, LVN 2 stated that hand washing should be done after three to four residents. LVN 2 stated she did not perform hand washing because the sink was far. The LVN stated the hand hygiene was important for residents because it places them at risk for cross contamination. During an interview on 4/4/25 at 11:22 p.m. with Infection Preventionist (IP-professionals who make sure healthcare workers and health facilities are doing all the things they should to prevent infections from spreading), the IP stated her expectation was to perform hand hygiene before entering the residents' rooms, coming out of the residents' rooms, before and after resident care and between residents during medication administration. The IP stated staff was expected to wash hands with soap and water after care for residents who are on Enhanced Barrier Precaution (EBP- an infection control intervention to reduce transmission of infections). The IP stated hand hygiene was important to prevent cross contamination and the spread of infections. During a review of facility's policy and procedure (P&P) titled, Medication Administration, dated 4/2024, the P&P indicated, . Wash hands prior to administering medication . During a review of facility's policy and procedure (P&P) titled, Hand Hygiene, dated 5/2024, the P&P indicated, .All staff will perform proper hand hygiene procedures to prevent the spread of infection . 2. During an observation on 4/1/25 at 10:08 a.m. in Resident 16's room, Resident 16's oxygen NC tubing was observed not in a protective bag on top of the oxygen concentrator and in direct contact with the wall. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 16's AR, the AR indicated, Resident 16 was admitted to the facility on [DATE] with a diagnosis which included Chronic Obstructive Pulmonary Disease (COPD- a common lung disease that makes it difficult to breathe) and acute respiratory failure with hypoxia (lungs are suddenly not able to get enough oxygen into their blood, causing a lack of oxygen throughout their body). During a review of Resident 16's Order Summary Report (OSR), dated 4/4/25, the OSR indicated, . [Resident 16] . Order Summary: Oxygen- At 2 liters (unit of measurement) per/minute via Nasal cannula Every Shift . Order status: Active .Start Date/By: 2/25/25 . During an interview on 4/2/25 at 2:50 p.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the oxygen NC should not have been left out on top of the oxygen concentrator touching the wall. LVN 3 stated tubing needed to be replaced and put into the protective bag when the resident was not using it. LVN 3 stated cross contamination could have occurred with the NC not in the protective bag when not in use. During an interview on 4/4/25 at 11:22 a.m., with the IP, the IP stated the oxygen nasal cannula touching the wall on top of the concentrator was unacceptable. The IP stated the potential outcome for a resident could be an infection, compromising the health of Resident 16. The IP stated cross contamination for Resident 16 could have occurred. The IP stated staff did not follow the facility policy and procedure for Oxygen Administration. During a review of facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2/2023, the P&P indicated, . Keep delivery devices covered in plastic bag when not in use . 51271 During an observation on 4/3/25 at 9:22 a.m. CNA 4 exited a resident room without performing hand hygiene, entered Resident 9's room without performing hand hygiene, assisted Resident 9 with their out-of-reach call light, and left the room without performing hand hygiene out. During the review of Resident 9's Admission Record, dated 4/3/25, the AR indicated Resident 9 was admitted on [DATE] with the diagnosis of: dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and muscle weakness (decreased strength in muscles). During a review of Resident 9's MDS, dated [DATE], the MDS BIMS- , which indicated Resident 4 had severe cognitive impairment. During an Interview with CNA 4 on 4/3/25 at 9:41 a.m. CNA 4 stated the importance of performing hand hygiene while going in and out of resident rooms was to prevent cross contamination. During an interview with Licensed Vocational Nurse (LVN) 1 on 4/3/25 at 11:49 a.m. LVN 1 stated we are to perform hand hygiene in and out of resident rooms. LVN 1 stated this was important because they did not want to spread germs (living things that can be found everywhere) to other residents. LVN 1 stated ensuring proper hand hygiene helped reduce the risk of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON) on 4/3/25 at 4:56p.m. the DON stated that her expectation of staff was to perform hand hygiene when entering and exiting resident rooms. The DON stated CNA 4 should have performed hand hygiene when she entered and exited Resident 9's room. The DON stated her expectation of staff was to perform hand hygiene upon entering and exiting resident rooms, even if they were not touching anything, as it ensured germs were not carried from room to room. During a review of facility's policy and procedure (P&P) titled, Hand Hygiene, dated 5/2024, the P&P indicated, .All staff will perform proper hand hygiene procedures to prevent the spread of infection .staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51271 Based on observation, interview and record review the facility failed to ensure call lights were within reach for two of six sampled residents (Resident 4 and 9) when call lights were observed on the floor and tucked in bedside drawers out of resident reach. These failures had the potential for Resident 4 and 9 to have delayed medical attention, increased risk of falls, prolonged discomfort or pain, feelings of isolation and anxiety (feeling of worry or nervousness), and in severe cases, life-threatening situations. Findings: During a review of Resident 4's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes) dated 5/23/24, the AR indicated, Resident 4 was readmitted on [DATE] with the diagnosis of: congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition and inactivity). During a review of Resident 4's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive (the way we think and learn) abilities), dated 2/27/25, the MDS indicated, a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of 15 out of 15 total score (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 4 had no cognitive impairment. During a concurrent observation and interview on 4/1/25 at 12:33 p.m. in Resident 4's room, Resident 4 was observed lying in bed with no call light. The call light was observed on the floor and out of reach. Resident 4 stated he could not get a hold of staff when the call light was on the floor. During the review of Resident 9's Admission Record, dated 4/3/25, the AR indicated Resident 9 was admitted on [DATE] with the diagnosis of: dementia (a progressive state of decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and muscle weakness (decreased strength in muscles). During a review of Resident 9's MDS, dated [DATE], the MDS indicated a BIMS score of four, which indicated Resident 4 had severe cognitive impairment. During a concurrent observation and interview on 4/3/25 at 9:22 a.m. in Resident 9's room, Resident 9 was observed to hit the wall of her room to get staff attention because her call light was out of reach. Resident 9 stated it was difficult to get staff's attention without a call light, as she was supposed to call for help. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055047	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Palms Care Center	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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Certified Nursing Assistant (CNA) 4 on 4/3/25 at 9:41 a.m., CNA 4 stated the residents needed to have their call lights within reach so they could get help. CNA 4 stated if the call light was not accessible, the resident would not have been able to call for help, which could have led to a fall and potential injury. During an interview with Licensed Vocational Nurse (LVN) 1 on 4/3/25 at 11:49 a.m., LVN 1 stated, Call lights were supposed to be within the resident's reach, not on the floor or stuffed in a drawer. LVN 1 stated residents would be at risk for falling if they got out of bed on their own because they could not find their call light. During an interview with the Director of Nursing (DON) on 4/3/25 at 4:56 p.m. the DON stated it was her expectation for staff to ensure call lights be within Residents' reach. The DON stated, Call lights should not be on the floor or stuffed in a drawer. The DON stated the risk to the resident was that if they needed help, they could not get a hold of staff, and the resident could potentially fall while getting up unassisted. During a review of the facilities policy and procedure (P & P) titled Call lights: Accessibility and Timely Response, dated 8/2024, the P&P indicated, .Staff will ensure the call light is within reach of the resident .will be accessible to the resident while in bed .