STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on interview and record review, the facility failed to ensure licensed nurse immediately consulted with resident's physician during a significant change in resident's physical status for two of three sampled residents (Resident 1 and 2) when: 1.Licensed nurses did not immediately notify Resident 1's physician, after Resident 1 experienced a severe unplanned weight loss of 18 pounds (lbs- a unit of measurement) or 9.8% in 28 days; on 12/3/23 weighed 166 lbs. Nursing staff obtained weekly weights documenting the rapidly declining weights and did not notify the physician of the change in condition (CIC) in accordance with physician expectations and policy and procedure; and did not conduct an Inter Disciplinary Team (IDT-an interdisciplinary team comprised of professionals from various disciplines who work in collaboration to address a resident with multiple physical and psychological needs) meeting to discuss the CIC. The Registered Dietitian (RD) input orders to fortify (added nutrition) Resident 1 ' s diet on 12/22/23 and Licensed Nurses (LNs) did not implement the orders until 12/28/23. LNs did not call the RP (responsible party) in accordance with the signed Power of Attorney (POA- legal document allowing someone else to act on your behalf) when Resident 1 had a change of condition. These failures resulted in not providing Resident 1 ' s physician the opportunity to determine the cause of the rapid decline in weights and clinical status, a delay in providing nutritional support to Resident 1 and contributed to Resident 1 being found unresponsive on 1/15/24 which required an ambulance transport to a higher level of care to a local acute care hospital (ACH). At the ACH, Resident 1 was immediately treated for high levels of ammonia (waste product processed by liver) in the blood and hepatic encephalopathy (damaged liver causes temporary worsening of brain function). 2. Resident 2 had blood in the urine on 12/30/23 and Licensed Nurses (LN's) did not ensure timely physician notification to provide prompt UTI [urinary tract infection-infection in bladder] treatment to Resident 2 which resulted in the delay in collecting the urine sample on 1/3/24. This failure resulted in prolonging the start of antibiotics to treat UTI. Resident 2 received the first dose of antibiotics on 1/11/24. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	1. During a review of Resident 1's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 1 was admitted to the facility on [DATE]. Resident 1's diagnosis included constipation, hypertension (high blood pressure), and muscle weakness. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive (mental process) and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment scored was 11 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 had moderate cognitive impairment. During a review of Resident 1 ' s Advanced Health Care Directive Form (AD) dated 12/22/23, the AD indicated, .When agents authority becomes effective: My agent ' s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I make the following box. If I mark this box [box marked], my agent ' s authority to make health care decisions for me takes effect immediately . During a telephone interview on 2/14/24 at 3:20 p.m. with Social Services (SS), SS stated Resident 1 ' s Responsible Party (RP) came to the facility on [DATE] with a notary (appointed official serving as an impartial witness) to sign the POA. SS stated she was present when the notary and Resident 1 ' s RP were signing the POA. SS stated from 12/22/23, LNs should call the RP for any health-related decisions. During a telephone interview on 2/15/24 at 9:36 a.m. with RP, RP stated she became the POA in 12/22/23 and wanted the facility to call her with any changes Resident 1 experienced. RP stated prior to Resident 1 being sent out to the hospital she had voiced her concerns to the LNs that Resident 1 was not responsive, not eating, and was sleeping most of the time. RP stated she had been asking the LNs to do blood work to find the underlying cause of Resident 1 ' s decline. RP stated losing 20 lbs in less than a month was a red flag and the LNs did not act upon her requests. RP stated if the LNs had called her when Resident 1 had a change of condition, she would have instructed them to send Resident 1 to the hospital. During a concurrent telephone interview and record review on 2/16/24 at 10:55 a.m. with RD, Resident 1 ' s weight review dated 12/15/23 was reviewed. The RD weight review indicated, .Wt [Weight] 172 [pounds] . Wt change: -12 lbs x 1 week .Res [Resident] continues to tolerate diet as ordered with an excellent PO [by mouth] intake which meets estimated needs .wt loss is likely r/t [related to] fluid balance shifts. No new RD recommendations . RD stated Resident 1 had edema [swelling caused fluid trapped in the body's tissues] and was taking medications to eliminate excess fluids. RD stated the goal was to maintain Resident 1 ' s weight in the 180lb range. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	During a concurrent telephone interview and record review on 2/16/24 at 11:10 a.m. with RD, Resident 1 ' s weight review dated 12/22/23 was reviewed. The RD weight review indicated, .Wt [Weight] 167 [pounds] . Wt change: -5 lbs x 1 week .Res [Resident] continues to tolerate diet as ordered, . intake is excellent and meets estimated needs . however, res continues to have wt loss .Res was happy with wt loss before as it was likely r/t fluid balance shifts, however this further wt loss may be r/t underlying medical conditions .RD recommends fortified [added nutrition], large portion diet with PBJ [peanut butter jelly] sandwich TID [three times a day] between meals to increase energy intake and minimize risk for further wt loss .Goal: resident will tolerate diet to meet estimated needs and will have gradual wt gain to maintain 172 +/- 5 lbs . RD stated when Resident 1 continued to lose weight and no longer had edema the weight loss became a concern. RD stated LNs should contact the physician when there is a significant weight loss so the physician can order laboratory (labs- facility conducting testing and analysis). RD stated he communicates his recommendations via email to the Director of Nurses (DON), LNs, and MDS. RD stated his expectation was for LNs to implement his recommendations within 48 hours. RD stated his recommendation was not started until 6 days later, the purpose of his recommendation was to increase calories (nutritional value of foods). RD stated increasing calories was intended to minimize tissue loss and decrease the chances of malnutrition (lack of proper nutrition). During a concurrent telephone interview and record review on 2/16/24 at 11:20 a.m. with RD, Resident 1 ' s weight review dated 1/2/24 was reviewed. The RD weight review indicated, .Wt [Weight] 166 [pounds] . Wt change: -8 lb x 1 week, -18 lbs x 1 month .skin intact no edema noted. Res continues to tolerate diet as ordered with a good PO intake which meets estimated needs .Res Is concerned with wt loss and requests high calorie . To ensure that needs are met .RD recommends [nutritional drink] 4 oz [ounce-unit of measure] TID to ensure that needs are met and weight is maintained at 166 +/-5lb . RD stated he was worried about Resident 1 ' s weight loss and recommended [nutritional drink]. RD stated he did not know why Resident 1 kept losing weight as he was a good eater, but his weight kept declining. RD stated on 1/2/24 was his last assessment of Resident 1. During a concurrent interview and record review on 2/20/24 at 11:04 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1 ' s Care Plan (CP) dated 12/10/23 was reviewed. The CP indicated, . Monitor/record/report to MD [medical doctor] PRN [as needed] .significant weight loss: 3lbs in 1 week, > [greater than]5% in 1 month . LVN 1 stated the purpose of the care plan was for staff to follow interventions created for Resident 1. LVN 1 stated the care plan was not followed because Resident 1 had weight loss since 12/15/23 and the physician was not called until 1/4/24. During a concurrent interview and record review on 2/20/24 at 11:10 a.m. with LVN 1, Resident 1 ' s Progress Notes (PN) dated 12/28/23 was reviewed. The PN indicated, RD recommendations fortified large portion diet and PBJ sandwich .between meals reviewed with MD, order in place . LVN 1 stated RD placed the recommendation on 12/22/23 and was not implemented until 12/28/23 (six days after the RD written recommendations). LVN 1 stated the RD ' s recommendation should be implemented right away. LVN 1 stated the purpose of the recommendation was to ensure Resident 1 received adequate nutrition. During a concurrent interview and record review on 2/20/24 at 11:20 a.m. with LVN 1, Resident 1 ' s electronic medical record (EMR) for weights and vitals summary dated 11/30/23 to 1/14/22 was reviewed. The vital signs weights indicated Resident 1's weights were: 11/30/23 181 lbs (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	12/3/23 184 lbs 12/10/23 172.0 lbs 12/17/23 167 lbs 12/24/23 174 lbs 12/31/23 166 lbs 1/9/24 163 lbs 1/14/24 161 lbs LVN 1 stated the physician should have been notified of the three pound plus or minus weight change for Resident 1 when it was identified. LVN 1 stated the physician was not notified until 1/4/24. LVN 1 stated the purpose of calling the physician was so he could conduct an assessment and make recommendations. LVN 1 stated there should have been a Change in Condition (CIC) done for Resident 1 ' s weight loss which would have triggered the LN to call the physician but was not done until 1/4/24. During a review of Resident 1 ' s Progress Notes (PN) dated 1/4/24, the PN indicated, . weight loss . meal intake is good . recently started on [nutritional drink] three times a day . no edema to exts [extremities] noted . primary care provider responded . recommendations: weekly weights . MD . in facility and made aware . During a concurrent interview and record review on 2/20/24 at 11:30 a.m. with LVN 1, Resident 1 ' s PN dated 1/10/24 was reviewed. The PN indicated, .Resident [RP] in facility .Per resident OK to talk to her regarding care/medications .per [RP] she would like [MD] to see resident she expressed concerns: .over weight loss .wants labs .kidney [part of body removing waste] function .possible underlying causes of weight loss .unable to reach Dr .vm [voicemail left] . LVN 1 stated Resident 1 ' s RP was concerned and the LN should have called the MD more than once. LVN 1 stated there was no other calls placed to the MD until Resident 1 had a CIC on 1/4/24. LVN 1 stated there were two other MD ' s and a Nurse Practitioner (NP) that could have been called. LVN 1 stated if it was not documented it was not done. LVN 1 stated the LN should have followed up with the RP ' s request to prevent delaying interventions the MD may order. During a concurrent interview and record review on 2/20/24 at 11:40 a.m. with LVN 1, Resident 1 ' s PN dated 1/12/24 was reviewed. The PN indicated, . change in condition . seems different than usual tired, weak, confused, or drowsy . at medication pass, resident c/o[complained of] not feeling good, feeling really tired . Resident refused to go out to hospital for further eval[evaluation]. Refuse to eat breakfast and lunch. Recent weight loss noted . complains of feeling sleepy . primary care provider responded . blood tests urinalysis or culture . LVN 1 state RP was Residents 1 ' s POA and should have been called when Resident 1 had a CIC and refused to go to the hospital. LVN 1 stated there was no documentation that the RP was called. During a review of Resident 1 ' s PN dated 1/13/24, the PN indicated, . received the lab result notified the M/D [Medical Doctor] put the result M/D binder . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s PN dated 1/15/24, the PN indicated, . unresponsive .CNA [certified nursing assistant] reported that patient was not responding to her. Upon assessment patient was found unresponsive. Eye open blinking tongue sticking out slightly MD notified . may transfer to hospital for further evaluation . During a telephone interview on 2/20/24 at 12:49 p.m. with MD, MD stated his expectation was that LNs call and notify him when there is a significant weight change. MD stated he has provided the facility with his cell phone, home phone and office number. MD stated he was the medical director of the facility, and the ultimate goal was to keep residents safe. During a review of Resident 1 ' s General Acute Care Hospital History and Physical (H&P) dated 1/15/24, the H&P indicated, . altered mental status . called [facility name] . per charge nurse she does not usually take care of patient and so she only has a very limited information . mentioned that patient reported that he was not feeling good and was feeling tired last few days. She does not have any further information . also spoke with patients [RP] . she states that for past several days patient has been sleepy and lethargic [drowsy or sleepy] and in recent few weeks, he has had significant weight loss. She states that she has had to repeatedly ask the staff at the nursing facility to order some labs and do work up to figure out why he was so sleepy . ammonia [waste product processed by liver] noted to be 135 [normal range 10-47] lactulose [medication used to treat complications of liver (organ in the body)] . and rectal [anus] tube ordered .admit to telemetry [hospital unit] . During a concurrent interview and record review on 2/20/24 at 1:15 p.m. with the Director of Nursing (DON), the facility Policy and Procedure (P&P) titled Weight Assessment and Intervention dated 3/2022 was reviewed. The P&P indicated, . resident weights are monitored for undesirable or unintended weight loss or gain . undesired weight loss will be based on the following criteria .1 month -5% weight loss is significant . undesirable weight changes evaluated by the treatment team . the physician and the multidisciplinary team identify conditions and medications that may be causing . weight loss or increasing the risk of weight loss . care planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident ' s legal surrogate . Interventions for undesirable weight loss are based on careful consideration . The DON stated there was no IDT meeting until 1/4/24 for Resident 1 ' s weight loss. The DON stated the purpose of the IDT meeting was to identify trends and preventions for continuous weight loss taking risk factors into consideration. The DON stated the care plan should be implemented and followed by LNs. The DON stated the RD sends his recommendations to herself, managers, and the dietary supervisor. The DON stated recommendations from the RD should be communicated and implemented the day it was recommended. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 2/20/24 at 1:20 p.m. with the DON, the facility Policy and Procedure (P&P) titled Change in a Resident ' s Condition or Status 02/2021 was reviewed. The P&P indicated, . our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition .A significant change of condition is a major decline or improvement in the resident status that . will not normally resolve itself without intervention by staff or by implementing standard disease related clinical interventions . unless otherwise instructed by the resident, a nurse will notify the resident ' s representative when . there is a significant change in the resident ' s physical, mental or psychosocial [individual's mind or behavior] status . The DON stated when Resident 1 had significant weight loss the physician should have been notified so he can review and identify the cause. The DON stated the expectation was that LN ' s call other physicians when they were unable to reach Resident 1 ' s primary physician. The DON stated there were more than three physicians the LNs could have attempted to call but did not. During a concurrent interview and record review on 2/20/24 at 1:31 p.m. with the DON, the facility Policy and Procedure (P&P) titled Advance Directives dated 09/2022 was reviewed. The P&P indicated, . resident has the right to formulate an advance directive . Advance directives are honored in accordance with state law and facility policy . the residents wishes are communicated to the residents direct care staff and physician by placing the advance directive documents in a prominent, accessible location in the medical record and discussing the residents wishes in care planning meetings . the plan of care for each resident is consistent with his or her documented treatment preferences and/or advanced directive . The DON stated Resident 1 ' s RP should have been called when he had significant weight loss, CIC and when Resident 1 refused to go to the hospital. The DON stated Resident 1 ' s RP was the POA and should be the one to make decisions for Resident 1. During a telephone interview on 3/4/24 at 1:08 p.m., with RD, RD stated Resident 1 lost a total of 18 lb ' s from 12/3/23 to 12/31/23 which was 9.8% weight loss. RD stated since admission 11/30/23 to 1/14/24 Resident 1 had 20 lb 11% weight loss. During a review of the facility LN ' s Duty Statement (DS) titled Floor Nurse undated, the DS indicated, . the purpose of your job position is to provide each resident with routine daily nursing care and accordance with current federal, state, and local standards that govern the facility and as directed by your supervisor . they will relate all pertinent information concerning a resident ' s condition to a charge nurse when required . Timely reporting of change in resident ' s condition to the nurse supervisor . Abiding with all facility policies and procedures . During a professional reference reviewed retrieved from https://my.clevelandclinic. org/health/diseases/21220-hepatic-encephalopathy, Hepatic Encephalopathy, dated 12/19/23, indicated, . These toxins build up in your blood and affect your brain, causing confusion, disorientation, and other changes. Hepatic encephalopathy can get better with treatment, but it can be life-threatening . Hepatic encephalopathy is brain dysfunction caused by liver dysfunction. Encephalopathy is brain dysfunction, and hepatic means liver-related . Any symptoms of overt hepatic encephalopathy are serious. It ' s important to treat the condition as soon as possible to prevent it from worsening or causing permanent damage. Severe hepatic encephalopathy can advance to coma or even death . In general, if the causes affecting you are brief, and if they ' re relatively mild, you ' re more likely to recover fully. If you have a permanent condition, you ' ll need ongoing therapy . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	2. During a review of Resident 2's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2's diagnosis included chronic kidney disease (inability to filter waste products from your blood). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 2's Brief Interview for Mental Status (BIMS -assessment of memory and judgment) assessment scored was 6 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, 00-07 indicates severe impairment). The BIMS assessment indicated Resident 2 had severe cognitive impairment. During a review of Resident 2 ' s Progress Notes (PN) dated 12/30/24, the PN indicated, .during brief change resident had blood in urine, blood bright red .will notify MD [medical doctor] . During a review of Resident 2 ' s PN dated 12/31/24, the PN indicated, .Resident has x1 episode of slight red in urine .faxed .communication to doctor .no response at this time . During a concurrent interview and record review on 2/20/24 at 11:45 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 2 ' s PN dated 1/1/23 was reviewed. The PN indicated, .Received fax from M.D. new orders received u/a [urinalysis -test if the urine] with c&s [culture and sensitivity-test used to determine medication used for infection] . LVN 1 stated the purpose of promptly notifying the physician was to get recommendations on interventions for the blood in urine. LVN 1 stated LN ' s should have attempted to call each shift or called another physician since 12/30/23 to prevent any delays. LVN 1 stated there was no documentation that the physician was called each shift to address the blood in urine from 12/30/23 -1/1/24. During a review of Resident 2 ' s PN dated 1/1/24, the PN indicated, .15:12 [3:12 p.m.] .Unable to collect urine specimen refused for catheterization [flexible tube used to collect urine] PM shift . During a review of Resident 2 ' s PN dated 1/2/24, the PN indicated, .01:41 [a.m.] .Unable to collect UA via catheter, resident refused x3 times, will endorse to oncoming shift . During a review of Resident 2 ' s PN dated 1/2/24/, the PN indicated, 20:59 [8:59 p.m.] .Staff offered to use the bathroom in PM shift refuses to get OOB [out of bed]. MD notified . During a concurrent interview and record review on 2/20/24 at 11:55 a.m. with LVN 1, Resident 2 ' s PN written by the Nurse Practitioner (NP) dated 1/3/24 was reviewed. The PN indicated, .Today the patient was seen for painful urination .Patient was complaining of urinary urgency, frequency, and painful urination . collected urine sample by myself using .cath [catheter] .cloudy in appearance . LVN 1 stated it took 5 days from when blood was identified in the urine to collect the urine for laboratory (facility provides test results). LVN 1 stated LN ' s should have called the MD when they were unable to collect the urine but didn ' t until 1/2/24 at 8:59 p.m. LVN 1 stated if it was not documented it was not done. During a telephone interview on 2/20/24 at 1:05 p.m. with MD 2, MD 2 stated if a resident refuses to have the UA collected, LN ' s should call him to ask for any follow up recommendations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0580 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 2 ' s PN dated 1/11/24, the PN indicated, .order for [levofloxacin-medication used to treat infection] 500 mg [milligram-unit of measure] x10 days for UTI [urinary tract infection-infection in bladder] . During a concurrent interview and record review on 2/20/24 at 1:58 p.m. with the DON, the facility Policy and Procedure (P&P) titled Change in a Resident ' s Condition or Status was reviewed. The P&P indicated, .our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident ' s medical/mental condition .The nurse will notify the resident ' s attending physician or physician on call when there has been a .significant change in the resident ' s physical .condition .refusal of treatment or medications two (2) or more consecutive times .The nurse will record in the resident ' s medical record information relative to changes in the resident ' s medical/mental condition . The DON stated after the second refusal of collecting the urine the LN ' s should have called the MD but didn ' t. The DON stated the blood in the urine was identified on 12/30/23 and took 5 days to collect the urine on 1/3/24. The DON stated the expectation was that LN ' s call other physicians when they were unable to reach Resident 2 ' s primary physician. During a professional reference reviewed retrieved from https://www.mayoclinic. org/diseases-conditions/urinary-tract-infection/symptoms-causes/syc-20353447, titled Urinary Tract Infection, dated 9/14/22, indicated, . A urinary tract infection (UTI) is an infection in any part of the urinary system . UTIs don't always cause symptoms. When they do, they may include . signs of blood in the urine . When treated promptly and properly, lower urinary tract infections rarely lead to complications. But left untreated, UTIs can cause serious health problems .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on interview and record review, the facility failed to ensure a baseline resident-centered care plan was developed and implemented for two of three sampled residents (Resident 3, and 4) when: 1.Resident 3 did not have a care plan for chronic obstructive pulmonary disease (COPD- lung disease making it difficult to breathe) until after being discharged from the facility and Resident 4 did not have a care plan until onsite investigation. 2. Resident 3 did not have a care plan for end stage renal disease (ESRD-inability to remove waste products from blood and produce urine) on dialysis [is a process by which dissolved substances are removed from a patient's body by diffusion (movement or spread) from one fluid compartment (space) to another across a semipermeable membrane (a layer that only certain molecules (smallest particle of a substance) can pass through] until after being discharged from the facility. This failure placed Resident 3 and 4 at risk for complications from not having care needs planned by licensed nurses to determine if nursing interventions needed to be added, changed, or completed. Findings: 1.During a review of Resident 3's Admission Record (document containing resident demographic information and medical diagnosis) undated, the admission record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnosis included chronic obstructive pulmonary disease (COPD- lung disease making it difficult to breathe). During a concurrent interview and record review on 3/5/24 at 11:32 a.m., with LVN 2, Resident 3's Order Summary(OS), dated 1/3/24 was reviewed. The OS indicated, Oxygen at 4 LPM (liters per minute) VIA NASAL CANNULA (NC- (thin plastic tube that delivers oxygen directly into the nose through two small prongs) Continuously DX: COPD. LVN 2 stated Resident 3 was on oxygen due to his diagnosis of COPD. LVN 2 stated Resident 3 was sent to the hospital on 1/10/24 and did not return. LVN 2 stated there was no care plan for COPD developed until 1/12/24. LVN 2 stated a care plan should have been developed as soon as the oxygen orders were received. LVN 2 stated care plans should be developed upon resident admission to the facility. During a concurrent interview and record review on 3/5/24 at 1:35 p.m. with the Assistant Director of Nursing (ADON), the facility Policy and Procedure (P&P) titled Care Plans-Baseline dated 3/2022 was reviewed. The P&P indicated, .A baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . the baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum health care information necessary to properly care for the resident including, but not limited to the following . initial goals based on admission orders . physician orders . ADON stated the purpose of the care plan was to make a plan of care to see if the interventions are appropriate. ADON stated it was the responsibility of the Licensed Nurse ' s (LN ' s) to make the care plan. ADON stated the care plan should have been developed within 48 hours. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Admission Record undated, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnosis included chronic obstructive pulmonary disease. During a concurrent interview and record review on 3/5/24 at 2:35 p.m., with ADON, Resident 4's Order Summary(OS), dated 2/29/24 was reviewed. The OS indicated, Oxygen at 2 LPM (liters per minute) VIA NASAL CANNULA DX: dyspnea (shortness of breath). ADON stated there was no care plan for COPD developed until 3/5/24. ADON stated a care plan should have been developed within 48 hours of admission. 2. During a review of Resident 3's Admission Record undated, the admission record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnosis included End Stage Renal Disease. During a concurrent interview and record review on 3/5/24 at 11:32 a.m., with LVN 2, Resident 3's Order Summary(OS), dated 1/4/24 was reviewed. The OS indicated, Dialysis schedule: Monday, Wednesday, Friday. LVN 2 stated there was no care plan developed related to the diagnosis of ESRD. LVN 2 stated Resident 3 was on dialysis and a care plan should have been developed on admission. During a concurrent interview and record review on 3/5/24 at 1:35 p.m. with the ADON, the facility Policy and Procedure (P&P) titled Care Plans-Baseline dated 3/2022 was reviewed. The P&P indicated, .A baseline plan of care to meet the resident ' s immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission . the baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum health care information necessary to properly care for the resident including, but not limited to the following . initial goals based on admission orders . physician orders . The ADON stated a care plan should have been developed within 48 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41119 Based on interview and record review, the facility failed to provide services which met professional standards of quality for two of four sampled residents (Resident 3, and 4) when Licensed Nurses 's (LN)'s did not administer oxygen per physician's order for residents (Resident 3 and 4) when physician ordered parameters for oxygen administration were not followed. This failure had the potential for Resident 3 and 4 to receive inadequate amount of oxygen. Findings: During a review of Resident 3's Admission Record undated, the admission record indicated Resident 3 was admitted to the facility on [DATE]. Resident 3's diagnosis included chronic obstructive pulmonary disease (COPD- lung disease making it difficult to breathe). During a concurrent interview and record review on 3/5/24 at 11:16 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 3's Order Summary(OS), dated 1/3/24 was reviewed. The OS indicated, Oxygen at 4 LPM(liters per minute) VIA NASAL CANNULA (NC- (thin plastic tube that delivers oxygen directly into the nose through two small prongs) Continuously DX: COPD. LVN 2 stated Resident 3 was on oxygen due to his diagnosis of COPD. During a concurrent interview and record review on 3/5/24 at 11:30 a.m. with LVN 2, Resident 3 ' s PN dated 1/4/24 and 1/10/24 was reviewed. The PN indicated, .1/4/2024 .On 3L oxygen via nasal canula .1/10/24 . Resident noted with oxygen at 87% at 3L/min via nasal cannula . LVN 2 stated both LN ' s documented the wrong oxygen rate. LVN 2 stated the oxygen should have been at 4L per MD order. LVN 2 stated it was standard of practice to follow MD orders. LVN 2 stated LN ' S should have checked the MD orders to ensure Resident 3 was not receiving less oxygen than ordered. During a review of Resident 4's Admission Record undated, the admission record indicated Resident 4 was admitted to the facility on [DATE]. Resident 4's diagnosis included chronic obstructive pulmonary disease. During an observation on 3/5/22, at 11:40 a.m., in Resident 4's room, Resident 4 was lying in bed, he had a Nasal Cannula on with the oxygen set at 3.5 liters. During a concurrent observation and interview on 3/5/24, at 11:55 a.m., with LVN 3, in resident 4's room, Resident 4 was lying in bed, he had a NC on with the oxygen set at 3.5 liters. LVN 3 stated the oxygen rate was set at 3.5 liters, it should have been set at 2 liters. During a concurrent interview and record review on 3/5/24 at 11:58 a.m., with LVN 3, Resident 4's Order Summary(OS), dated 2/29/24 was reviewed. The OS indicated, Oxygen at 2 LPM via nasal cannula. LVN 3 stated it was professional standard of practice to follow physician orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055147	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Rehabilitation & Nursing Center	517 South A Street Madera, CA 93638

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/5/24 at 1:31 p.m. with the Assistant Director of Nursing (ADON), the facility Policy and Procedure (P&P) titled Oxygen Administration dated 10/2010 was reviewed. The P&P indicated, .safe oxygen administration .proper flow of oxygen is being administered . ADON stated it was professional standard of practice to follow MD orders. ADON stated the oxygen rate should be set at the rate ordered by the MD. ADON stated LN ' s should have checked the MD ' s orders to ensure the oxygen rate was correct. During a review of Registered Nursing.org Professional Reference titled, Does a Nurse Always Have to follow a Doctor's Orders? undated, (found at https://www.registerednursing.org/does-nurse-always-follow-doctors-orders/) indicated, .nurses cannot just randomly decide which order to follow and which not to follow. Unless there is a safety concern or an order that conflicts with personal or religious beliefs, failing to carry out orders can be grounds for discipline by the employer as well as the board of nursing, as it could be deemed neglect.