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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to report abuse allegations to the California Department of Public Health (CDPH) within the required timeframe for two of four sampled residents (Resident 10 and Resident 7) when: 1. CNA 5 alleged CNA 6 pushed Resident 10 roughly onto her bed while providing care on 4/5/25 and did not report the allegation of abuse to the facility until 4/6/25. 2. Family Member (FM) 1 contacted the local police department (PD) alleging Resident 7 was abused by facility staff on 3/5/25 and 3/27/25, the PD went to the facility for welfare checks and the facility staff was made aware of the abuse allegations. The facility staff did not report the abuse allegations to CDPH on 3/5/25 and 3/27/25 according to federal regulations and the facility's policy and procedure (P&P). This failure resulted in the abuse allegations not being investigated timely and had the potential to result in Residents 10 and 7's safety needs not being met. Findings: 1. During a review of Resident 10'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 4/6/25, the AR indicated, Resident 10 was admitted to the facility on [DATE], with diagnosis which included, right femur fracture (a broken thigh bone), dementia (a decline in mental abilities, like memory thinking, and reasoning), dysphagia (trouble swallowing), cognitive communication deficit (trouble reasoning and making decisions while communicating), need for assistance with personal care, muscle weakness, and abnormalities of gait and mobility (trouble walking and moving). (continued on next page)

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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) assessment, dated 3/30/25, the MDS assessment 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 of 11 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) assessment score was 7 out of 15 which indicated Resident 10 had severe cognitive impairment. The MDS assessment indicated Resident 10 had a history of falls with injury prior to admission to the facility. During a review of the facility's document titled, Post-Event Review- V2 (PR), dated 4/6/25, the PR indicated the alleged abuse incident was observed on 4/5/25 at 6:00 a.m. by CNA 5. The PR document indicated CNA 5 reported the alleged abuse incident to the facility on [DATE] at 4:00 a.m. During a review of the facility's document titled, Conclusion of Reported Unusual Occurrence, dated 4/7/25, the document indicated the alleged abuse incident was reported to the facility on [DATE]. The document indicated the facility concluded their internal investigation on 4/7/25 with no evidence of abuse. The document indicated the internal investigation report was faxed to CDPH on 4/8/25. During a concurrent observation and interview on 4/15/25 at 11:08 a.m. with Resident 10 and Resident 10's husband (HB) in Resident 10's room, Resident 10 was observed lying in bed and the bed was in the lowest position. The HB was seated beside Resident 10's bed. Resident 10 was not observed with any visible bruises, cuts or scratches to the face, neck, forearms, or hands. Resident 10 stated she did not remember being pushed or harmed on 4/5/25. Resident 10 stated she had never been harmed or pushed at the facility. Resident 10 stated she felt safe at the facility. The HB stated on 4/6/25 he was notified a staff member allegedly pushed Resident 10 on 4/5/25. The HB stated he visited Resident 10 after he was notified of the alleged abuse incident, and Resident 10 was free from physical and emotional injury. The HB stated Resident 10 had dementia and was often confused but could remember same day events. The HB stated Resident 10 did not mention any harm or abuse when he asked her on 4/6/25. The HB stated he felt Resident 10 was safe at the facility. The HB stated family visited Resident 10 everyday and had no concerns with the care received at the facility. During an interview on 4/15/25 at 5:19 p.m. with CNA 5, CNA 5 stated on 4/5/25 at 6:00 a.m. she observed Resident 10 standing at the edge of her bed which was in the lowest position, closest to the ground. CNA 5 stated she left to retrieve a wheelchair so Resident 10, who was a fall risk, did not fall. CNA 5 stated CNA 6 stated she would return Resident 10 back to bed so she would not fall. CNA 5 stated when she returned to Resident 10's room she observed, from the doorway, CNA 6 placed her hands on Resident 10's arms and pushed her down onto the bed. CNA 5 stated she did not report the incident until 4/6/25 at 4:00 a.m. to Licensed Vocational Nurse (LVN) 6. CNA 5 stated she was in shock and did not know what to do after she witnessed the incident. CNA 5 stated she was aware alleged abuse incidents were to be reported within two hours. CNA 5 stated she received training on abuse, neglect, and mandated reporting guidelines on orientation, annually and after the alleged incident. CNA 5 stated it was important to report all alleged incidents of abuse within two hours to ensure resident safety. (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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/16/25 1t 8:14 a.m. with LVN 6, LVN 6 stated CNA 5 reported the alleged abuse incident to her on 4/6/25 at 4:00 a.m., twenty-two hours after the alleged abuse incident. LVN 6 stated she immediately reported the allegation to all required entities which included, the Administrator (ADM), the Director of Nursing (DON), the Medical Doctor (MD), the Police Department (PD), the Ombudsman (OMD), CDPH, and Resident 10's Responsible Party (RP), per facility policy. LVN 6 stated she told CNA 5 all allegations of abuse were expected to be reported within two hours. LVN 6 stated all staff within the facility were mandated reporters (a person legally required to report suspected or known cases of abuse, neglect or mistreatment) and she expected all CNAs to report allegations of abuse within two hours. LVN 6 stated it was important to report allegations of abuse within two hours to ensure resident safety and prevent other residents from potentially being harmed by the perpetrator until an investigation could be completed. During an interview on 4/17/25 at 10:48 a.m. with CNA 6, CNA 6 stated on 4/5/25 at 6:00 a.m. Resident 10 was observed standing at the edge of her bed, which was in the lowest position, closest to the ground. CNA 6 stated Resident 10 removed her clothing, and she attempted to assist her back into bed. CNA 6 stated CNA 5 left to retrieve a wheelchair for Resident 10 to sit in. CNA 6 stated Resident 10 was unsteady on her feet, and she tried to help hold Resident 10 up by her hands and lower back. CNA 6 stated Resident 10 started to sit down and collapsed down onto the bed. CNA 6 stated Resident 10's bed was in the lowest position, closest to the ground, and she was unable to raise the bed before Resident 10 sat down quickly. CNA 5 denied the allegation of abuse. During an interview on 4/17/25 at 2:13 p.m. with the ADM, the ADM stated the alleged abuse incident was witnessed by CNA 5 on 4/5/25 at 6:00 a.m. The ADM stated CNA 5 reported the alleged abuse incident on 4/6/25 at 4:00 a.m. to LVN 6. The ADM stated LVN 6 notified him by phone call of the alleged abuse incident on 4/6/25 at 4:00 a.m. The ADM stated he was the abuse coordinator, and he started the internal abuse investigation on 4/6/25 at 7:30 a.m. when he arrived at the facility for the day. The ADM stated CNA 5 was a mandated reporter and was required to report all allegations of abuse within two hours to the facility and to the required entities. The ADM stated CNA 5 did not report the allegation of abuse within two hours to the facility or required entities. The ADM stated it was important to report all allegations of abuse within two hours to ensure allegations of abuse were investigated within required timeframes and to ensure the immediate safety of all residents within the facility. During a review of the facility's policy and procedure (P&P) titled, Abuse Investigation and Reporting, undated, the P&P indicated, .all alleged violation of abuse, neglect, exploitation or mistreatment .will be reported immediately, but no later than .two (2) hours if the alleged violation involves abuse . During a review of the facility's in-service document titled, Preventing Elderly Abuse/Mandated Reporter, dated 1/6/25, 1/7/25, and 1/18/25, the in-service indicated, .all alleged abuse must be reported right away to supervisor, administrator and DON .mandated reporters Certified Nursing Assistant . mandated reporters must report known or suspected instances of physical abuse, abandonment, isolation, financial abuse, or neglect .immediately . The in-service included education on types, signs and examples of abuse. The in-service included education on when and how to report abuse. The in-service indicated CNA 5 and CNA 6 received and completed the annual in-service before the alleged abuse incident was reported. (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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's in-service document titled, Abuse Reporting, dated 4/7/25, the in-service indicated, .all staff are mandated reporters and are required to report all instances of suspected abuse, actual abuse, and injuries of unknown origin immediately .time frame to report alleged abuse: within 2 hours . The in-service indicated CNA 5 received and completed the in-service on 4/7/25 after the alleged abuse incident was reported. During a review of the facility's job description titled, Certified Nursing Assistant, undated, the job description indicated, .they will make sound independent decisions when circumstances warrant such action . will relate all pertinent information concerning a resident's condition to a charge nurse when required .abiding with all facility policies and procedures . During a review of the professional reference review retrieved from https://oag.ca.gov/system/files/media/your-legal-duty-curriculum.pdftitled, Your Legal Duty-Reporting Elder and Dependent Adult Abuse, dated 2/2023, the professional reference review indicated, .under California law, every employee at a long-term care facility has a legal duty to report known or suspected incidents of elder or dependent adult abuse .each of the following are a mandated reporter . all other employees in a long-term care facility .mandated reporters are legally responsible for the reporting of suspected or known abuse . immediately, and no later than two hours after observing or suspecting the abuse . 2. During an observation on 4/14/25 at 10:48 a.m., Resident 7 was observed lying in bed with her eyes closed. Resident 7 opened her eyes when spoken to but closed her eyes again. Resident 7 was unable to carry on a conservation and did not answer any questions. Resident 7 was under a blanket and her arms were not visible, there was no bruising or discoloration noted to her neck or face. During a review of Resident 7's Admission Record, undated, the admission record indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia (progressive loss of memory and thinking), pressure ulcer (injuries to the skin and underlying tissue caused by prolonged pressure) and mental disorder (disorder affecting mood, thinking and behavior). During a review of Residents 7's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 7's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 03 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 7's cognition was severely impaired. During a review of Resident 7's Health Status Note, dated 3/5/25 at 10:30 a.m., the note indicated, . writer was notified by another staff member that PD [police department] was here to do a wellness check on resident [Resident 7] at 1030 [10:30 a.m.]. This writer went towards the room and waited in the hallway while the PD asked resident questions in Spanish . PD finished asking her questions this writer asked what happened. PD stated that a family member had called in to do a wellness check because every time she comes to see the resident, she has new bruises on her . (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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 7's Health Status Note, dated 3/27/25 at 9:13 p.m., the note indicated, . [FM 1] called [Name of police department] to report elder abuse, at 2100 [9:00 p.m.] [Name of PD] arrived to follow up on the complaint . Writer explained to officer no suspected abuse report was done as the complaint was about episode of incontinence [loss of control of urination and leakage of stool], resident is incontinent of bowel and bladder . 2nd complaint the dinner tray was far from resident, explained resident requires feeding assistance . 3rd concern was resident having no pants . 4th complaint the blouse resident is was wearing was tied to her leg with a knot, RP [responsible party] showed the pictures of the blouse allegedly been tied . there is no knot on pictures shown . Then at 2100 [Name of PD] arrived to follow up . During a telephone interview on 4/17/25 at 3:21 p.m. with Licensed Vocational Nurse (LVN) 7, LVN 7 stated she was Resident 7's nurse on 3/5/25. LVN 7 stated she frequently took care of Resident 7. LVN 7 stated the police department had been to the facility twice, once on 3/5/25 when she was the charge nurse and once on 3/27/25. LVN 7 stated FM 1 had reported Resident 7 had bruises and new skin issues to the police on 3/5/25. LVN 7 stated the police came in and were asking the staff if they were feeding the resident, cleaning her and things like that. LVN 7 stated FM 1 frequently accused the staff of not changing or cleaning Resident 7. LVN 7 stated she notified the supervisor when the police had arrived. LVN 7 stated the staff handled Resident 7 with care, but her skin was fragile due to her health and her arms would become bruised and discolored easily. LVN 7 stated Resident 7's skin was breaking down because she was frail and on hospice (specialized medical care focused on comfort at the end-of-life). LVN 7 stated she did not report the abuse allegation on 3/5/25, because she knew the facility staff was not abusing the resident. LVN 7 reviewed a note in Resident 7's Health Status Note, dated 3/27/25 at 9:13 p.m., and stated the note indicated FM 1 had called the police and reported elder abuse. LVN 7 stated she was not sure if an SOC 341 was completed, but abuse allegations were supposed to be reported to the Ombudsman and CDPH within two hours. During a telephone interview on 4/17/25 at 4:49 p.m. with Certified Nursing Assistant (CNA) 10, CNA 10 stated Resident 7 was usually assigned to her, and she was familiar with her. CNA 10 stated Resident 7 was frail, frequently refused care and refused to eat. CNA 10 stated her coworkers had told her there were allegations of abuse from the family. CNA 10 stated she had never seen any signs of abuse. CNA 10 stated Resident 7's skin was very fragile, and her skin would become discolored during routine care. CNA 10 stated the Administrator (ADM) was the facility's abuse coordinator. During a telephone interview on 4/18/25 at 1:20 p.m. with the Director of Nursing (DON), the DON stated all instances of alleged abuse needed to be reported to the Ombudsman, state agency and police within two hours of the incident being reported or being made aware of the situation. The DON stated she was not aware FM 1 had made accusations of abuse to the police and staff did not notify her when the police had shown up to the facility. The DON stated FM 1 did not speak with her regarding her concerns. The DON stated if she was made aware of the allegations, she would have reported it to the State Agency and the Ombudsman. The DON stated the ADM was the facility's abuse coordinator. (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	04/15/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/24/25 at 3:00 p.m. with the ADM, and the Administrator Consultant (ADMC), the ADM stated he was the facility's abuse coordinator. The ADMC stated he and the ADM were not aware the police had come to the facility twice. The ADMC stated they first heard about the allegations on 4/18/25 during the investigation. The ADMC stated the allegations of abuse should have been reported to the Ombudsman and CDPH within two hours of the police arrival at the facility. The ADMC stated the expectation was for the staff to notify management immediately when there were allegations of abuse so they could make sure the resident was not abused. The ADMC stated they needed to be notified timely so they could follow up appropriately and it was not up to the staff to decide if an abuse allegation was substantiated or not. The ADMC stated it was the facility's policy and procedure (P&P) to report allegations of abuse within two hours. During a review of the facility's P&P titled, Abuse, Neglect, Exploitation and Misappropriate Prevention Program, dated 4/2021, The P&P indicated, . Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation . Protects residents from abuse . Develop and implement policies and protocols to prevent and identify . abuse or mistreatment of residents . neglect of residents . Identify and investigate all possible incidents of abuse . Investigate and report any allegations within timeframes required by federal requirements . Protect residents from any further harm during investigations . During a review of the facility's P&P titled Abuse Investigation and Reporting, dated 7/2017, the P&P indicated, . All reports of resident abuse, neglect . injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations and thoroughly investigated by facility management . If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the administrator will assign the investigation to an appropriate individual . An alleged violation of abuse, neglect, exploitation or mistreatment . will be reported immediately, but not later than . Two (2) hours if the alleged violation involved abuse OR has resulted in serious bodily injury .

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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42123 Based on observation, interview, and record review, the facility failed to ensure residents received adequate supervision to prevent falls for two of five sampled residents (Residents 1 and 9) when: 1. Resident 1 was assessed to be at risk for falls on 3/23/25 and staff were aware of Resident 1's frequent positioning in bed lying on his back leaning against the side rail, right sided paralysis (inability to move), and inability to reposition himself and effective individualized interventions to prevent falls were not implemented. Resident 1 experienced an unwitnessed fall on 4/2/25. This failure resulted in Resident 1's avoidable fall on 4/2/25 when he was found on the floor face down next to his bed, sustaining a nasal fracture [broken nose], a laceration (deep cut in the skin) to the left eyebrow and left shin (front of the leg below the knee) requiring transportation to the emergency department (ED) for assessment and treatment of his injuries. Resident 1 received eleven sutures (stitches holding the edges of a wound together) to his left eyebrow and seven sutures to his left shin. The resident was treated in the ED and transferred back to the skilled nursing facility (SNF). 2. Resident 9 was assessed as needing staff supervision to ambulate (walk) more than 50 feet and had known behaviors of putting herself on the ground and effective individualized interventions to prevent falls were not implemented when she ambulated outside to the memory care unit patio without staff supervision. Resident 9 experienced an unwitnessed fall on 4/6/25. This failure resulted in Resident 9's avoidable fall on 4/6/25 when she sustained a 1-centimeter (cm-unit of measurement) laceration to the back of her head and required transportation to the emergency department for assessment. Resident 9's wound did not require sutures, and she was transferred back to the skilled nursing facility. Findings: 1. During a concurrent observation and interview on 4/14/25 at 10:17 a.m. with Resident 1 in his room, Resident 1 was lying in bed on his back, his upper body was leaning to the left with his weight against a pillow on the side rail. The bed was against the wall on Resident 1's right side and to the left side there was a landing mat on the floor with an overbed table (portable, adjustable table to be placed beside or over the bed) close to him. Resident 1's left eyebrow had a laceration with sutures and the surrounding area was swollen and discolored. The tip of Resident 1's nose pointed slightly to the left. Resident 1 was alert, able to answer yes or no and speak in single words, but unable to carry on a conversation. Resident 1 was asked if he was comfortable in that position, he stated no and attempted to move his body to the right but was unable to. Resident 1 was asked if he had a fall recently and he replied yes and gestured to the floor. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's Admission Record (AR- a document containing resident medical and personal information), undated, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness to one side of body) following cerebrovascular disease (disease affecting the blood flow to the brain) affecting the right dominant side (side of body being preferred for tasks), congestive heart failure (chronic condition where heart muscles is weakened and cannot pump blood efficiently), epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), abnormalities of gait (manner of walking) and mobility (ability to move freely), aphasia (a language disorder that affects communication), lack of coordination, abnormal posture, and muscle weakness. During a review of Residents 1's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 1's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) was based on staff assessment. Resident 1 was assessed as having a memory problem with severe cognitive impairment related to daily decision making. During a review of Resident 1's Post-Fall Review, dated 4/2/25, the note indicated, . Date and Time of Fall . 4/2/25 15:20 [3:20 p.m.] . Discovered on the floor (Unwitnessed) . Resident found lying on the floor by supervisor. Resident lying prone [face down] position with small cut to left upper side of eyebrow. Resident also noted to have blood on his left shin . Residents complain about pain . paramedics [medical professional who provides emergency care outside of a hospital] were called assisted resident to gurney [a wheeled stretcher] and took resident to hospital . resident unable to tell what he was doing . Continence [ability to voluntarily control bowel (feces) and bladder (urine)] at time of fall . Wet . Soiled . returned to the facility around 0430 [4:30 a.m. on 4/3/25] . discharge diagnosis stated that he has a fracture [break in a bone] to his lt [left] and rt [right] nasal bones . laceration to the lt eyebrow and the wound to the lt shin and they were closed with sutures, 11 to the forehead [eyebrow] and 7 to the lt shin . During a concurrent observation and interview on 4/14/25 at 10:20 a.m. with Resident 1's roommate, Resident 2, Resident 2 stated he had been Resident 1's roommate for about a year. Resident 2 stated the day of Resident 1's fall, Resident 2 was lying in bed and heard a loud bam, then Resident 1's overbed table moved. Resident 2 stated the curtain between their beds was closed but he could see Resident 1 lying on the ground next to Resident 1's bed under the curtain. Resident 2 stated he started yelling for a nurse because Resident 1 could not call for one. During an interview on 4/14/25 at 11:19 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was taking care of Resident 1 today. CNA 4 stated she was not at work when Resident 1 fell on [DATE]. CNA 4 stated Resident 1 would always lean to the left against the side rail, so the staff kept a pillow between him and the siderail for comfort. CNA 4 stated Resident 1 was paralyzed on his right side and was not able to reposition himself or try to get up, so she was not sure how he fell out of bed over the siderail if it was in the proper position. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/14/25 at 2:12 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Resident 1 on the day of his fall. LVN 1 stated she was at a nurses meeting when Resident 1 fell and was called to his room. LVN 1 stated when she walked into Resident 1's room, he was lying face down on the floor, between his bed and the overbed table, and his eyebrow was bleeding. LVN 1 stated Resident 1 was physically dependent on two people to change his position, move in bed, and required a mechanical lift (device used to safely lift and transfer patients with limited mobility) to be moved out of the bed into a chair. LVN 1 stated Resident 1 was at risk for falls because of his paralysis and limited mobility. Resident 1's fall risk care plan dated 7/9/2018 was reviewed and indicated, . at risk for falls with injury r/t [related to] CVA [cerebrovascular accident-loss of blood flow to the brain damaging tissue] with hemiplegia and hemiparesis, epilepsy, impaired balance . anticipate and meet [Resident 1's] needs . Encourage resident to keep bed low . Encourage [Resident 1] to participate in activities that promote exercise . Pt [physical therapy] evaluate and treat as ordered or PRN [as needed] . LVN 1 stated Resident 1's issue with positioning and leaning up against the side rail was a known problem, but not addressed in the care plan. LVN 1 stated she was unsure how Resident 1 fell out of bed if the side rail was in the correct position. LVN 1 stated she did not notice what Resident 1's bed height or side rail position was at the time of his fall. During a concurrent interview and record review on 4/14/25, at 2:48 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 1's fall risk assessment dated [DATE] was reviewed, the assessment indicated, .Based on the answers . is resident at risk for falls . yes . The MDS Section GG-Functional Status, dated 2/8/25 was reviewed and indicated, . Mobility . Roll left and right . code 01 [Dependent-helper does all of the effort . Sit to lying . code 88 [not attempted due to medical condition or safety] . The MDSC stated Resident 1 could not physically reposition himself in bed. During an interview on 4/14/25 at 4:37 p.m. with LVN 2, LVN 2 stated she was the evening charge nurse at the time of Resident 1's fall on 4/2/25. LVN 2 stated Resident 1 was at risk for falls because he had a history of leaning to the left against the side rail in bed and was unable to reposition himself and had a diagnosis of seizures. LVN 2 stated Resident 1 would lean against the side rail to the left because his right side was paralyzed, and he could not use the right side of his body to move back to the center of the bed. LVN 2 stated she did not know how Resident 1 fell over the top of his side rail. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 4/14/25 at 4:45 p.m. with CNA 3, in Resident 1's room, CNA 3 stated she was assigned to Resident 1 at the time of his fall on 4/2/25. CNA 3 stated she was in a nearby room and heard Resident 2 yelling for help. CNA 3 stated she ran into the room and Resident 1 was face down on the floor between his bed and the overbed table. CNA 3 stated she could not move Resident 1 because of potential injuries so she yelled for a nurse. CNA 3 stated the Assistant Director of Nursing (ADON) came into the room and stated to not move Resident 1 because of a potential back or neck injury. CNA 3 stated Resident 1 was lying flat on his face, agitated and cursing. CNA 3 stated he had blood on his face, and they left him in that position until the paramedics came and put him on the gurney. CNA 3 stated Resident 1 was a high fall risk because the resident was totally paralyzed on the right side of his body and unable to move it which causes him to slide to the left and lean against the side rail while on his back. CNA 3 stated Resident 1 could not pull himself back to the center of the bed because of his paralysis. CNA 3 stated Resident 1 had an electric bed and had behaviors of putting it up in the high position despite being reminded to keep the bed low. CNA 3 stated she was not sure if Resident 1's bed was in high or low position at the time of his fall. CNA 3 stated Resident 1 sustained a cut to his left eyebrow and left shin. CNA 3 pulled Resident 1's covers back with his permission and a long, jagged laceration was observed on his left shin with a reddish swollen scab above it. During an observation on 4/15/25 at 11:19 a.m. with Resident 1 in his room, Resident 1 was sitting in bed with the head at a 45-degree angle (a semi-sitting position). Resident 1 was lying on his back, leaning to the left against a pillow on the side rail. During an interview on 4/15/25 at 2:01 p.m. with LVN 4, LVN 4 stated Resident 1 preferred to lie on his back and would frequently lean against the side rail. LVN 4 stated Resident 1 was non-compliant with using his call light to ask for help with positioning. During a concurrent interview and record review on 4/15/25 at 2:54 p.m. with the ADON, the ADON stated the nursing staff was in a meeting on 4/2/25 at the time of Resident 1's fall. The ADON stated she was walking in the hall and heard a CNA yell for help. The ADON stated she walked into Resident 1's room and he was lying face down on the floor between his bed and the overbed table. The ADON stated he was bleeding from a laceration to his head, but she could not assess the laceration because she did not want to move the resident in case of a neck or back injury. The ADON stated she was not sure if the side rail was in the proper position or what the height of his bed was. The ADON stated the right side of Resident 1's body was paralyzed, and he frequently leaned to the left against the side rail. The ADON stated Resident 1 had the side rails to assist with turning as much as possible during care and to prevent him from falling out of bed. The ADON stated we cannot stop him from falling. The ADON stated the goal was to try to minimize his fall risk and the risk of injury. The ADON stated the staff would remind him to use his call light and keep his bed in a low position, but she was not sure if he could retain any education provided. Resident 1's care plan was reviewed, the ADON stated there were no care plan interventions addressing the resident lying against his side rails throughout the day and his inability to reposition himself. The ADON reviewed the MDS section GG and stated Resident 1 was dependent on staff for bed mobility. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/15/25 at 4:25 p.m. with the Director of Nursing (DON), the DON stated Resident 1 had an unwitnessed fall on 4/2/25. The DON stated the IDT (Interdisciplinary Team-involves team members from different disciplines working collaboratively, with a common purpose, to set goals, make decisions and share resources and responsibilities for the best interest of the resident) was unable to determine the root cause of Resident 1's fall. The DON stated Resident 1 was at high risk for falls. Resident 1's fall risk care plan was reviewed, the DON stated Resident 1's fall prevention interventions prior to his 4/2/25 fall was to anticipate needs, encourage the resident to participate in activities, Restorative Nursing Assistant (RNA-provides rehabilitative care to patients to help regain and maintain the physical functioning and independence) program and encourage the resident to keep the bed in a low position. The DON stated Resident 1 had an electric bed and would put it in the high position by himself. The DON stated she was unsure how high the bed was at the time of his fall. The DON stated she was aware Resident 1 would lean to his left side against the side rails but was unable to locate care plan interventions addressing his positioning. During a telephone interview on 4/16/25 at 9:08 a.m. with the Director of Rehabilitation (DOR), the DOR stated she would screen the residents after falls to see if they would benefit from a therapy evaluation. The DOR stated she screened Resident 1 after his fall, but determined he would not benefit from therapy. The DOR stated Resident 1 was at his maximum potential, dependent on staff for mobility and activities of daily living (basic self-care tasks such as eating, bathing, and mobility). The DOR stated Resident 1 had non-compliant behaviors, would not call for assistance with positioning and had a behavior of putting his electric bed in a high position. The DOR stated Resident 1 had no trunk control and was unable to move himself back to center in bed. The DOR stated Resident 1 would frequently lean to the left in bed, against the side rail. The DOR stated Resident 1 needed two staff to move him back to the center of the bed. The DOR stated the CNAs needed to frequently check Resident 1's position and make sure he was lying in the center of the bed and not leaning to the left because he could not reposition himself. During a review of Resident 1's Change in Condition [CIC] Evaluation, dated 4/14/25, the CIC indicated, . cellulitis left lower leg . MD made aware . Carry out new order . During a review of Resident 1's ACH document titled Discharge Instructions, dated 4/2/25, the document indicated, . Reason for Visit . Fall . Discharge Diagnosis . Head trauma (left sided) . History of CVA with right sided deficit . Hematoma [closed wound with a collection of blood] of left lower leg . Long term current use of anticoagulant [medicine to prevent blood clots] . Fall . Nasal bone fracture . You were seen in the emergency department after sustaining a fall from your bed . you did sustain a fracture of your left and right nasal bones . There is minimal deviation [shift in position] of the bones . follow-up with an ear nose and throat doctor . we were able to repair the lacerations above your left eyebrow and on your left leg . During a review of Resident 1's acute care hospital document titled ED Physician Notes, dated 4/3/25, the document indicated, . Procedure . Laceration repair . 4/2/25 . Laceration 1.9 cm in length. Lower extremity: left . Shape: irregular . Skin closure . sutures . During a review of Resident 1's acute care hospital document titled ED Physician Notes, dated 4/3/25, the document indicated, . Procedure . Laceration repair . 4/2/25 . Laceration 3.2 cm in length. Face: left, eyebrow . Shape: linear . clean, surrounding tissue contused [bruised] . Skin closure . sutures . (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1's ACH document titled Radiology Report, dated 4/2/25, the report indicated, . CT [computed tomography scan- type of imaging that uses X-ray techniques to create detailed images of the body] Maxillofacial [jawbones and the face] [wo [without] Con [contrast] . FINDINGS . Soft tissue swelling/laceration in the left frontal scalp and periorbital [area around the eye] region. Acute minimally displaced [broken bone where the ends are not aligned] leftward deviated fracture of the left nasal bone. Acute nondisplaced leftward deviated fracture of the right nasal bone . During a review of Resident 1's ACH document titled XR [x-ray] Tibia [the shinbone] +Fibula [smaller of the two lower leg bones], dated 4/2/25, the Xray indicated, . INDICATION . fall/dropped at rehab facility . FINDINGS . Diffuse Osteopenia [bones are weaker than normal] . No definite acute fracture . Diffuse soft tissue swelling . During a review of the facility's document titled The 4 P's [Potty, Position, Pain, Placement] of Fall Prevention, undated, the document indicated, . Potty . Does your resident need to use the bathroom . Position . Is your resident in a comfortable position . Pain . Is your resident experiencing any pain . Placement . Are all the items your resident would like placed within reach . During a review of the facility's policy and procedure (P&P) titled Falls and Fall Risk, Managing, dated 2/7/24, the P&P indicated, . Based on previous evaluations and current data, the nursing staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . Resident conditions that may contribute to the risk of falls . other cognitive impairment . pain . lower extremity weakness . poor grip strength . medication side effects . functional impairments . Medical factors that contribute to the risk of falls . heart failure . neurological [related to the nervous system] disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident . During a review of the facility's P&P titled Safety and Supervision of Residents, dated 1/2024, the P&P indicated, . Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis . When accident hazards are identified, the facility staff shall review the events in an attempt to identify the root-cause and possible associated hazards . When safety risks can not be completely eliminated, such as the risk for falls and related injuries, the facility staff shall develop strategies to mitigate the risk for injuries . Resident supervision is a core component of the approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs . Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents . The care team shall targe t interventions to reduce individual risks related to hazards in the environment . Resident supervision is a core component of the approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs . 2. During an observation on 4/14/25 at 11:03 a.m., in the memory care unit, Resident 9 was observed sitting in the activities room. Resident 9 was sitting in a chair with her eyes half closed and appeared drowsy. During an observation on 4/14/25 at 11:05 a.m., the memory care unit outdoor patio was observed. The patio had a cement walkway which led to the main outdoor area for the residents. The main area was enclosed with a fence and the patio consisted of cement walkways and grassy areas. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 9's Admission Record, undated, the admission record indicated, Resident 9 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills), dementia (progressive loss of memory and thinking), epilepsy (nerve cell activity in the brain is disturbed causing seizures [burst of sudden electrical activity]), abnormalities of gait (manner of walking) and mobility (ability to move freely), muscle weakness and difficulty in walking. During a review of Residents 9's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 9's BIMS scored 03 of 15. The BIMS assessment indicated Resident 9's cognition was severely impaired. During a review of Resident 9's ACH document titled ED Assessment, dated 4/6/25, the document indicated, . Chief Complaint: Fall . Stated Complaint: GROUND LEVEL FALL/HEAD PAIN . Patient had an unwitnessed fall from a chair onto the ground . sustained a small laceration to the back of her head which does not need repair because of that less than 1 cm wide and is not bleeding . Diagnosis . Fall . Laceration of scalp . During an interview on 4/14/25 with CNA 1, CNA 1 stated she was usually assigned to Resident 9 and was caring for her today. CNA 1 stated she was aware Resident 9 had a recent fall but was not working at the time of the fall. CNA 1 stated Resident 9 had known behaviors of putting herself on the ground and walking around the facility with her eyes closed. CNA 1 stated Resident 9 had sustained a laceration to her head during the fall, but she was unsure if the resident had sutures or not. CNA 1 stated Resident 9 was known to be a high fall risk but would ambulate alone in the hallway and out on the patio. CNA 1 stated when she is outside, we keep an eye on her. CNA 1 stated the staff would check on Resident 9 every 15 to 20 minutes while she was outside on the patio. During a concurrent interview and record review on 4/14/25 at 2:48 p.m. with the MDSC, Resident 9's MDS Section GG-Functional Status, dated 2/17/25 was reviewed. The MDS indicated, . Walk 10 feet . code 05 [Setup or clean-up assistance-helper assists only prior to or following the activity] . Walk 50 feet . code 04 [Supervision or touching assistance] . Walk 150 feet . Code 04 . The MDSC stated Resident 9's MDS indicated she should have supervision to ambulate, and a CNA should always be with the resident when she was ambulating. The MDSC stated supervision during ambulation meant to have contact guard (to provide light guiding contact) from an employee. The MDSC stated Resident 9 should not have been on the patio without staff supervision. The MDSC stated she was familiar with Resident 9 had known behaviors of putting herself on the floor and walking with her eyes closed, increasing her need for supervision. During an observation on 4/15/25 at 11:36 a.m., in the memory care hallway, Resident 9 was observed walking in the hallway independently with her eyes half closed. Resident 9 was confused and unable to engage in conversation. CNA 1 took Resident 9 to her room. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent interview and record review on 4/15/25 at 2:54 p.m. with the ADON, Resident 9's Change in Condition, (CIC-documentation regarding a significant change from baseline) dated 4/6/25, was reviewed. The CIC indicated, . CNA Notified Charge Nurse that resident was found sitting on the floor outside in station 6 patio. Charge Nurse went to assess resident and noted Resident sitting on the floor with her legs extended out in front of her . The ADON stated Resident 9 had an unwitnessed fall on the memory care patio on 4/6/25. Resident 9's Post-Fall Review, dated 4/6/25 was reviewed, and indicated, . Date and time of fall . 04/06/2025 15:18 [3:18 p.m.] . Discovered on the floor (Unwitnessed) . Outside patio . Resident noted to have cut to her back of head with active bleeding at the incident time. Upon investigation resident had pattern of banging posterior head (backside of the head) on the ground . Root cause: May have Put self on the floor or due to poor safety awareness and impaired mobility due to self-transfer that resulting in her falling. Resident has pattern for laying on her back raise her head and drop it on the ground repeatedly . The ADON stated Resident 9 sustained a laceration to the back of her head and was sent to the ED for assessment, but did not require sutures so she was sent back to the SNF. Resident 9's fall risk care plan, dated 10/19/2019, was reviewed. The care plan indicated, . resident is at risk for falls with injury r/t [related to] epilepsy, anxiety [feeing of worry], difficulty in walking, muscle weakness generalized . resident Throws self on the floor, impaired cognition, poor safety awareness, history of falling . Behavior of walking with eyes closed . Anticipate and meet the resident's ADL care needs . Encourage the use of appropriate footwear . Keep bed in lowest position . PT [physical therapy]/OT [occupational therapy] eval [evaluation] and Tx [treat] as needed . Resident is ambulatory . Walk 10 Feet: Set or clean up assistance . Walk 50 Feet: Supervision or touching assistance . The ADON stated Resident 9 had known behaviors of sitting herself on the ground and walking with her eyes closed. The ADON stated Resident 9's care plan indicated she was supposed to have supervision to walk 50 feet and did not have supervision while on the patio at the time of her fall. The ADON stated the memory care unit patio was further than 50 feet from the memory care unit hallway and she should have had supervision. The ADON stated, we cannot prevent her from falling because of her behaviors. During a concurrent interview and record review on 4/15/25 at 4:25 p.m. with the DON, Resident 9's Post Fall Review, dated 4/6/25, was reviewed. The DON stated Resident 9's fall on 4/6/25 was unwitnessed and happened on the memory care unit's patio. The DON stated Resident 9's MDS dated [DATE], indicated she needed supervision to ambulate more than 50 feet, and the memory care unit hallway was more than 50 feet. The DON stated Resident 9 had dementia (decline in mental ability severe enough to interfere with daily life) and Alzheimer's Disease and was unable to make decisions regarding her safety. The DON stated, we cannot stop her from what she is doing. The DON stated she had been told by staff Resident 9 frequently went out to the patio unsupervised with no issues. The DON stated Resident 9 could go to the patio, but the DON declined to state if Resident 9 needed supervision while she was outside. The DON reviewed Resident 9's fall risk care plan and stated there were no interventions to address her known behaviors of putting herself on the floor until after the fall on 4/6/25. During a telephone interview on 4/16/25 at 9:08 a.m. with the DOR, the DOR stated Resident 9 was started on therapy after her fall on 4/6/25. The DOR stated she did a therapy screen for Resident 9, and she was started on physical therapy. The DOR stated Resident 9 was independent for ambulation indoors but was not safe to ambulate outside on uneven surfaces by herself. The DOR stated Resident 9 needed staff supervision while outside on the patio. (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	04/15/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few	During a review of the facility's policy and procedure titled Falls and Fall Risk, Managing, dated 2/7/24, the P&P indicated, . Based on previous evaluations and current data, the nursing staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . Fall Risk Factors . Resident conditions that may contribute to the risk of falls . other cognitive impairment . pain . lower extremity weakness . poor grip strength . medication side effects . functional impairments . Medical factors that contribute to the risk of falls . heart failure . neurological disorders . balance and gait disorders . implement a resident-centered fall prevention plan to reduce their specific risk factor(s) of falls for each resident .

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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42123 Based on interview and record review, the facility failed to ensure the Infection Preventionist (IP) have the specific competencies, and skill sets to ensure facility staff were properly trained and educated to properly managed and care for residents with infections and to prevent the risk for infections to other residents, staff and visitors when the IP did not provide on-going in-service training and education to facility staff when facility had an outbreak of Noro virus (highly contagious virus [easily spread] that causes vomiting and diarrhea) and Influenza virus (contagious respiratory illness). These failures placed residents, staff and visitors at increased risk for exposure to infections. Findings: During a concurrent interview and record review on 4/15/25 at 1:58 p.m. with Dietary Supervisor (DS), Inservice Meeting Minutes, dated 1/2/25 was reviewed. The DS stated the topic was on Infection Control in the dietary area only because of a Noro Virus and Influenza virus outbreak in the facility. The DS stated she discussed with her staff about wearing of surgical masks, hand washing and washing of isolation trays used in the isolation room. The DS stated she should have encouraged dietary staff to attend in-service training provided by IP on Noro virus and Influenza virus because the IP was more knowledgeable on the topic. The DS stated the IP leaves boxes of masks for staff to wear upon entry of the facility. The DS stated she did not remember attending in-services training on Noro virus and Influenza after the outbreak started. During an interview on 4/15/25 at 2:26 p.m. with Dietary [NAME] (DC), the DC stated the DS provided all in-services training to dietary staff. The DC stated she did not remember attending any infection control in-services training provided by the Infection Control Nurse. The DC stated she did not remember seeing a posted schedule of in-services on infection control. The DC stated dietary staff were told by the DS on what masks to use and the IP leaves boxes of masks outside the double door and a sign to wear the mask when entering the facility. (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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 4/15/25 at 3:24 p.m. with Infection Preventionist (IP), the IP reviewed Noro virus surveillance form and stated there was a total of four residents tested positive for the Noro virus. The IP stated the first case was confirmed on 1/2/25 and sample was collected on 1/1/25. The IP stated the last case was on 1/5/25. The IP stated Noro virus in-service training was provided to staff on 12/19/24. The IP stated the in-service training was provided 15 days prior to first known positive case. The IP stated she did not provide additional Noro virus in-service training to staff, and she should have to provide reminders and refresher to staff to safely care for positive residents and prevent spread of infection to other residents, staff and visitors. The IP stated, I am sure, and I hope staff remembered what was discussed in the in-service training on 12/19/24. The IP reviewed Influenza surveillance form and stated the first Influenza case was on 1/2/25. The IP stated one case of positive Influenza is considered an outbreak. The IP reviewed in-services training provided immediately after first known positive case of influenza. The IP stated only 23 staff attended in-service training on Influenza given on 1/2/25. The IP stated only 17 staff attended in-services training on Respiratory Illness/ droplet precautions given on 2/22/25. The IP stated only 47 staff attended in-service training titled Standard/Contact/Droplet/EBP/Hand Hygiene, provided on 1/7/25 and 24 staff attended on 3/10/25. The IP stated it was her responsibility to ensure all staff were educated and trained to care for residents and prevent spread of infection to other residents, staff and visitors. The IP stated she should have tried to offer and provide make up in-services training to all staff. The IP stated she did not remember communicating to administrator, Director of Nursing and Assistant Director of Nursing of low attendance during in-services training and she should have. During an interview on 4/15/25 at 4:57 p.m. with the Director of Staff Development (DSD), the DSD stated she had been the DSD in the facility since 2011. The DSD stated she did not provide Noro virus and Influenza virus in-services training to staff after the outbreak. The DSD stated it was the duty of the IP nurse to provide in-services training to staff on topics related to Infection Control. The DSD stated the IP did not ask for help with in-services training, if she did .I would have gladly assisted because I do a lot of training with staff and I used to be the IP. The DSD stated she provided Infection Control in-service training on 1/20/25. The DSD stated she schedules make-up in-service training to ensure all staff received the training and knowledge like everyone. During an interview on 4/15/25 at 2:39 p.m. with Dietary Aide (DA) 2, DA 2 stated she attended infection control in-service training given by her supervisor. DA 2 stated she did not remember attending infection control in-service given by IP. DA 2 stated she did not know if there were reminders posted by IP to attend in-services. DA 2 stated there is usually a box of masks outside of the double door with sign to wear the masks. During a phone interview on 4/16/25 at 11:50 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she did not remember attending Noro Virus and Influenza virus in-services training when facility had residents tested positive for the virus. LVN 1 stated in-services training are important to educate staff to care for residents affected by the virus and to prevent spread of virus to other residents, staff and visitors visiting the facility. During a phone interview on 4/17/25 at 9:1 a.m. with Registered Nurse (RN) 2, RN 2 stated she started working in the facility on 2/25. RN 2 stated Noro virus and Influenza virus outbreak started on 1/2/25. RN 2 stated she did not remember attending in-service training on Noro virus and Influenza virus. RN 2 stated in-service training was important to educate staff on how to care for affected residents and prevent the spread to other residents, visitors and staff. (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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview on 4/17/25 at 10:08 a.m. with Certified Nursing Assistant (CNA) 8, she stated she had been working in the facility since 2018. CNA 8 stated she did not remember if IP provided in-services training on Noro virus and Influenza virus after the first positive cases which resulted in an outbreak in the facility. CNA 8 stated she did not remember if there was any posting of make-up in-services training on the board to remind staff to attend in-services. CNA 8 stated it was important to attend in-service training to learn to care for residents and prevent the spread of infection in the facility. During a phone interview on 4/17/25 at 11:20 a.m. with CNA 9, she stated she did not remember attending in-service training on Noro virus and Influenza virus after the facility had outbreak of the viruses. CNA 9 stated she did not remember if facility or the IP offered an in-service training on Noro virus and Influenza virus. CNA 9 stated in-services training was important to educate staff to care for residents affected by the virus and to prevent spread of virus to other residents, staff and visitors. CNA 9 stated it was important for nursing staff to receive in-service training to care for residents. During a phone interview on 4/18/25 at 1:05 p.m. with the Director of Nursing (DON), the DON stated she assumed the role as DON on 2/4/25. The DON stated her role was to oversee the IP, making sure the right precaution was in place and in-services training are occurring. The DON stated, .In-services training was important because people tend to forget especially when there is an outbreak . The DON stated IP and DSD to continue to provide training and education to staff to ensure they (nursing staff) have the knowledge to safely care for residents. The DON stated her expectation was for IP and DSD to educate staff on interventions to prevent transmission of viruses or diseases to residents, staff and visitors. The DON stated the IP should have made sure she provided Noro virus in-service training to staff after the first confirmed case to care for residents safely and continued to provide in-service training until all staff providing resident care are 100 percent in attendance. The DON stated she expected the IP provided on-going Influenza virus in-services training to all staff to prevent the spread of infection. The DON stated the facility employs approximately 195 staff, the IP should have attempted to educate as much staff as possible and offered make up in-services specially nursing staff because they are providing hands on care to residents. The DON stated she did not know staff are not attending in-services training because the IP did not communicate to her. During a review of facility document titled, Infection Preventionist, Job Duties and Responsibilities, undated, the document indicated.accountable for decreasing the incidence of infectious diseases between patients, staff, visitors and the community . Authority and responsibility for ensuring appropriate interventions and education occurs with staff . Ensures that education and counseling on infection prevention is available for staff . Partners with department directors in providing in-service trainings . During a review of facility policy and procedure (P&P) titled, Norovirus Prevention and Control, dated 10/11, the P&P indicated, . During outbreaks, residents with norovirus gastroenteritis will be placed on contact precautions for a minimum of 48 hours after the resolution of symptoms . During outbreaks, use soap and water for hand hygiene after providing care or having contact with residents suspected or confirmed with norovirus gastroenteritis . Clean and disinfect shared equipment between residents . To prevent food-related outbreaks of norovirus gastroenteritis in healthcare settings, food handlers must perform hand hygiene prior to contact with or the preparation of food items and beverages . (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	04/15/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a professional reference review retrieved from https://www.cdc.gov/norovirus/outbreak-basics/index.html#cdc_outbreak_basics_when_how-when-and-how-outbreaks-happen. A norovirus outbreak is defined as: An occurrence of two or more similar illnesses resulting from a common exposure that is either suspected or laboratory-confirmed to be caused by norovirus . Most outbreaks of norovirus illness happen when infected people spread the virus to others through direct contact. This can happen by caring for them or sharing food or eating utensils with them. Food, water, and surfaces contaminated with norovirus can also cause outbreaks .The most commonly reported setting for norovirus outbreaks in the United States and other industrialized countries is healthcare facilities. This includes long-term care facilities and hospitals. Over half of all norovirus outbreaks reported in the United States occur in long-term care facilities. The virus can be introduced into healthcare facilities by infected patients, staff, visitors, or contaminated foods. Outbreaks in these settings can sometimes last months. Compared with healthy people, norovirus illnesses can be more severe-and occasionally even deadly-in patients in hospitals or long-term care facilities . During a review of facility policy and procedure (P&P) titled Influenza, Prevention and Control of Seasonal, dated 3/22, the P&P indicated, . When there is influenza activity in the local community, or one laboratory-confirmed influenza case is identified in the facility, active daily surveillance for influenza illness id conducted among all new and current residents, healthcare personnel visitors . All staff receive job- or task-specific education and training on preventing transmission of infectious agents, including influenza . New or revised information is provided during subsequent education and training . Competencies are evaluated and documented .