

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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** Based on observations, interviews and record review, the facility failed to ensure residents' environment remained free of accident hazards as possible when: 1. In the memory care unit, facility staff were aware an exit door was secured by a slide barrel lock (a type of lock that requires the user to slide the barrel of the lock in order to unlock the device) and placed on the door in a position that was out of reach for most individuals. An environmental hazard risk assessment was not done for the lock on the door. Some staff were unaware of the placement of the slide-barrel lock and residents were not trained to unlock the device. These failures resulted in the possibility of 26 of 26 residents ((Residents 8, 16, 18, 20, 23, 24, 31, 43, 45, 51, 56, 58, 60, 64, 75, 76, 88, 99, 104, 117, 136, 149, 156, 168, 172 and 187) and staff being unable to exit the door in an emergency and could lead to entrapment. These failures could affect all 26 memory care residents, representing widespread scope and severity and substandard quality of care. 2. Facility staff was aware of the path of travel to the smoking area from the entrance of the facility crossed the parking area and did not safely and effectively address the hazard posed to residents who smoke and travel the path in order to reach the smoking area. These failures resulted in one of 15 sampled residents (Resident 81) traveling the path on 7/15/25 at time and was struck by a vehicle while in his wheelchair. Resident 81 sustained an unavoidable fracture (break in bone) to his left distal fibula (lower, outer portion of the two long bones in the lower leg) and medial malleolus (bony prominence located on the inner side of the ankle joint) fracture and was admitted to general acute care hospital (GACH) from 7/15/25 through 7/21/25, an open reduction internal fixation (ORIF-surgical opening the fracture site to realign the bone fragments and then using internal hardware like screws, plates, or rods to hold pieces together) to repair the fracture was performed on 7/18/25. These injuries resulted in Resident 81's decreased independence in mobility and to experience pain which led to increased dependence on staff to meet all his activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily care for themselves) needs. During an observation on 08/05/25 at 1:06 p.m. a slide barrel lock was installed at the top right corner of an exit door located in the dining room located within the memory care unit leading out to a patio. During a concurrent observation and interview on 8/8/25 at 9:23 AM with the Director of Nurses (DON), DON observed the lock on the door and stated that she was not aware that this type of lock had been installed on the door. DON stated, "That lock can't be there". DON stated that she thinks this is very unsafe and needs to be replaced. DON stated that it is a, "huge safety issue". DON stated she never knew that the door had this type of lock installed. DON stated that in the event of an emergency the residents could not get out safely and the fire department could not get in easily. DON further stated that this could be considered a restraint. DON demonstrated that she was not able to reach the lock because the lock was installed high up on the door. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 055147	If continuation sheet Page 1 of 69

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a concurrent observation and interview on 08/08/25 at 9:42 AM with Maintenance Director (MAINT DIR) the door leading from the dining room to an outside patio was equipped with a lock. According to MAINT DIR the lock's design was a slide barrel lock and stated the lock was installed several months before. The MAINT DIR stated the position of the lock on the door, near the very top right corner of the door, prevented most individuals, including staff and residents to reach the lock and could result in the possibility of residents and staff unable to exit the door in an emergency and could lead to entrapment. MAINT Dir stated that the slide barrel lock requires some fine motor skills and cognitive understanding to operate. Residents in the memory care unit, many of whom may have dementia or Alzheimer's, may not be able to unlock them in an emergency, posing a serious risk during fire or evacuation situations. Locks like these can trap residents or staff inside or outside the building, especially if staff are unaware the lock has been engaged. MAINT DIR stated that there had been no facility risk or hazard assessment done on this door and lock. MAINT DIR removed the lock from the door. During a review of the facility's policy and procedure titled, "Exits or Means of Egress" revised date January 2024, indicated "primary and secondary exit doors will remain unlocked at all times"; During a review of professional reference from the Life Safety Code (NFPA 101) Published by the National Fire Protection Association (NFPA) in which it requires, "doors must be readily operable from the egress side when a building is occupied. Locks and latches should not require special knowledge or effort to operate from the egress side"; and "that all occupancies, including health care facilities, have unobstructed and readily accessible means of egress to allow for safe evacuation during emergencies"; (NFPA 101: Life safety Code, Means of Egress Requirements (NFPA, latest edition). 2. During a review of Resident 81's GACH document titled, "Physician History and Physical Note" dated 7/16/25, the note indicated, "presented to the emergency department [ED] after reportedly being struck by a pickup truck while seated in his wheelchair in a parking lot"; ED Imaging and Findings: CT [computed tomography scan or CAT scan-medical imaging procedures that uses X-rays[type of electromagnetic radiation used to create images of the inside of the body particularly bones] to create detailed cross-sectional images of the body) Bilateral Lower Extremities (7/15/25 21:09): Left leg: Comminuted, displaced acute traumatic fracture of the distal fibular shaft. Comminuted medial malleolus fracture. Moderate soft tissue swelling. Right Leg: No acute fracture or dislocation"; Discharge Summary"; Hospital course: "successful ORIF on 7/18/2025"; During a review of Resident 81's "admission Record," (AR-a document containing resident profile information) dated 7/16/25, the AR indicated, Resident 81 was admitted to the facility on [DATE] with diagnoses that included cerebrovascular disease (group of conditions that affect the blood vessels in the brain) dysarthria (speech disorder characterized by difficulty in articulating words and producing clear speech) and anarthria (complete loss of the ability to produce speech) history of alcohol abuse, muscle weakness, unspecified dementia (a progressive state of decline in mental abilities) and diabetes mellitus (DM- disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Residents 81's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 81's Brief Interview of Mental status assessment (BIMS & assessment of cognitive (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure two of sixteen sampled residents (Resident 2 and Resident 4) maintained acceptable parameters of nutritional status when: 1. Resident 2 was at risk of unplanned weight loss, and did not receive adequate nutritional interventions to maintain acceptable parameters of nutritional status. This failure resulted in a severe weight loss of 7.95% in less than 2 months from 6/2/25 to 7/28/25 without timely assessment, monitoring, or physician notification. 2. Resident 4 was admitted on [DATE] with a diagnosis of protein-calorie malnutrition (inadequate intake of protein and calories) and sustained a 9.58% unintentional weight loss from 5/30/25-6/27/25 with no nutritional therapeutic diet type or nutritional supplemental diet interventions (a targeted, evidence-based strategy to improve a person's nutritional status by adding dietary supplements to their regular diet. These interventions are customized to meet an individual's specific needs, often in conjunction with dietary counseling and other therapeutic approaches). This failure resulted in Resident 4 sustaining a 14.37 % unintentional weight loss from 5/30/25-7/17/25 before nutritional therapeutic diet type or nutritional supplemental diet interventions were added to Resident 4's plan of care which lead to an overall unintentional weight loss of 11.98% from 5/30/25-7/31/25 due to delayed identification of nutritional therapeutic diet type and nutritional supplemental intervention requirements. 1. During a record review of Resident 2's Medical Record (documents related to person's health information), the Medical Record indicated Res 2 had a weight loss of 8.4 pounds (lbs). Resident 2 weighed 105.4 pounds (lbs- unit of measurement) on 6/2/2025 and weighed 97 lbs on 7/28/2025. The Percentage of weight loss of 7.95% loss occurred in 56 days. The Care Plan (a written guide for how the nursing home staff will take care of a resident every day), did not reflect updated interventions to address this unplanned weight loss. There were no Interdisciplinary Team (IDT) notes to address Resident 2's weight loss. There were no Registered Dietitian (RD) notes to address Resident 2's weight loss or interventions. The weights for Resident 2 were documented as follows; 5/2/25 weight of 106 lbs, 6/2/25 weight of 105.4 lbs and 7/28/25 weight of 97 lbs. Diet (weight loss) Notes DATE WEIGHT May 2, 2025 106.0 lbs June 2, 2025 105.4 lbs July 28, 2025 97.0 lbs During an interview on 8/12/25 at 3:10 p.m., with Resident 2 and her daughter (RP 4) RP 4 stated Resident 2 spoke mostly Spanish. RP 4 stated Resident 2 has been on a soft, mushy diet which (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0692 Level of Harm - Actual harm Residents Affected - Few	Resident 2 did not like. Resident 2's daughter stated that her mom did not eat more than half her food in a day as she does not like how soft and mushy the food was and how the texture was hard for Resident 2. During a concurrent interview and record review on 8/13/25 at 1:36 p.m., with Licensed Vocational Nurse (LVN 4), LVN 4 stated that a resident with a weight loss of over 5% in that short amount of time should have had some type of intervention. LVN 4 stated she was unable to find an intervention, an updated care plan, a change of condition or a Situation, Background, Assessment and Recommendation (SBAR) communication forms documented regarding weight loss in Resident 2's medical record. LVN 4 stated it was very important to address weight loss in residents because they could become weaker. LVN 4 stated residents need to be on appropriate diet to get the best compliance of meal intake and the best nutrition. During a concurrent interview and record review with the Speech Language Pathologist (SLP) on 8/13/25 at 11:31 a.m., regarding Resident 2. The SLP stated that according to the medical record, Resident 2 was on a mechanical soft diet. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) MDS Section K (swallowing/Nutritional Status) and section L (Oral/Dental Status) indicated there were no issues found that would require extra care or special treatment in these areas. The SLP stated Resident 2 was not on his patient load. The SLP stated he was aware Resident 2 was unhappy with her diet and had not received a referral. The SLP reviewed Resident 2's medical record and could not find any type of intervention to address Resident 2's weight loss. The SLP stated it was important to address any resident with unplanned weight loss so that they can maintain their optimum health. The SLP stated a fortified/high protein diet should have been started immediately as soon as the weight loss was identified. The SLP stated Resident 2's severe weight loss was not identified. The SLP stated it was important to start residents on a fortified/high protein diet early on to prevent or slow down weight loss. During an interview via phone on 8/13/25 at 4:30 p.m., with the Registered Dietitian (RD), the RD stated she does not currently have access to the chart but was very well aware of Resident 2. The RD stated she was unaware of Resident 2's weight loss of 7.95% from 6/2/25 to 7/28/25. The RD stated Resident 2 must have come back from the hospital, dialysis or a family visit and that is why it did not get caught or triggered. The RD stated that weights should be done anytime residents return from the acute care hospital. The RD stated that she only looks at weights from week to week and does not do a look-back. The RD stated this weight loss should have been brought up by nursing in the IDT meeting but stated that it might have been overlooked for a number of reasons. The RD stated she was part-time and is 100% remote and does not see the residents. The RD stated there were two other RDs that help cover. The RD stated the RDs were responsible for ordering and overseeing residents' diets. The RD stated it was normal for residents to not be triggered, and weight issues not addressed in IDT meetings. The RD stated during the IDT meetings she is provided with too much information. The RD stated the staff goes over a lot of the weights and she only needs the current weight. During a concurrent interview and record review with the Director of Nursing (DON) on 08/14/25 at 2:00 p.m., the DON stated it was the RD's job to identify signs and symptoms of weight loss, and it was not the nurse's job. The DON stated that multiple interventions should be used such as supplements, addressing current diets, and preferences to help combat weight loss not just adding snacks as a first line defense. The DON stated the RD should be doing lookbacks not just focusing on (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	week-to-week weights. The DON stated that Nursing is not responsible for looking for interventions. This should come from the RD. DON stated she was unable to find any record of RD notes for weight loss in the chart and there were no IDT notes regarding weight loss. The DON stated it was important for the right diet to be ordered for the residents so that the residents have the opportunity to enjoy the correct diet. The DON stated the texture was important to achieve compliance and increased intake which may prevent weight loss. The DON stated not doing so can cause the residents emotional and physical harm. During a concurrent interview and record review with the DON on 08/14/25 at 3:12 p.m., the facility policy titled Nutrition (impaired)/Unplanned Weight Loss - Clinical Protocol was reviewed. The policy indicated, . the staff and physician will define the individual's current nutritional status (weight, food/fluid intake and pertinent laboratory values) and identify individuals with anorexia, weight loss or gain and significant risk for impaired nutrition .the staff will report to the physician significant weight gain or losses . The DON stated this did not occur. During a record review of the job description titled, Registered Dietician, the job description indicated, . assess the nutritional needs, nutrition diagnosis, intervention and evaluation of patient and document in the medical record . and . consults with physicians, IDT, healthcare professionals to determine nutritional needs of patients . During a record review of the document titled, Position Summary for Registered Dietitian on 08/13/2025 at 4:15 PM which states, . assess the nutritional needs, nutrition diagnosis, intervention and evaluation of patient and document in the medical record . and . consults with physicians, IDT, healthcare professionals to determine nutritional needs of patients . During a review of the Registered Dietician's signed job contract, titled, Healthcare Services Group, INC. Job Description, dated 06/15/2023, the job contract indicated, . completes comprehensive nutrition assessments. and completes comprehensive assessments in accordance with current standards of practice. During a review of the article/professional reference titled, Academy of Nutrition and Dietetics dated x/xx/xx, retrieved from https://www.eatrightpro.org/practice/nutrition-care-process/ncp-overview. The document stated that the Nutrition Care process is a systematic method that dietetics and nutrition professionals use to provide nutrition care for residents. The four steps include: Nutrition Assessment and Reassessment, Nutrition Diagnosis, Nutrition Intervention and Nutrition Monitoring and Evaluation. The Nutrition Assessment is the first step in the process and includes multiple domains including food and nutrition related history. Physical examination findings and tools that assess health or disease risk status, and progress evaluation. The second step, Nutrition Diagnosis is used to identify existing nutrition problems that the Registered Dietitian Nutritionist, RDN, is responsible for treating. The third step in the process is Nutrition Intervention and is customized to meet the individual's needs. Nutrition intervention requires goal planning and action (implementation) to meet those goals. The fourth and last step in the Nutrition Care Process is Nutrition Monitoring and Evaluation. This step measures the progress of the interventions and whether the plan needs to be revised. Academy of Nutrition and Dietetics. (2024). NCP [NAME]: Nutrition Care Process quality evaluation and standardization tool. Chicago, IL: Academy of Nutrition and Dietetics. 2. During a review of Resident 4's admission Record (AR - a summary of information regarding a (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 8/12/25, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes (T2DM-high blood sugar), protein-calorie malnutrition (PEM-inadequate intake of protein and calories), iron deficiency (body lacks sufficient iron), chronic kidney disease (CKD-progressive damage to kidneys and cannot filter blood adequately), dementia (progressive decline in memory and cognition), and altered mental status. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/2/25, the MDS indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 7 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 4 was severely cognitively impaired. During a review of Resident 4's MDS, dated 6/6/25, the MDS indicated Resident 4 had a Swallowing and Nutritional Status (a resident assessment tool used to identify resident's ability to maintain adequate nutrition and hydration, covering aspects like swallowing disorders, height, weight, weight loss, and nutritional approaches) assessment completed on admission with no identified swallowing or nutritional issues. During a review of Resident 4's Weights and Vitals Summary, dated 8/12/25, the document indicated, Resident 4's weights were .5/30/2025 167 lbs (pounds- a unit of weight measurement).6/6/2025 167 lbs.6/12/2025 164 lbs.6/19/2025 161 lbs.6/27/25 151 lbs.7/3/2025 149 lbs.7/10/2025 149 lbs.7/17/2025 143 lbs.7/24/2025 146 lbs.7/31/25 147 lbs. The document indicated Resident 4 had a 9.58 % weight loss in one month, from 5/30/25-6/27/25. The document indicated Resident 4 had a 14.37% weight loss in one and a half months, from 5/30/25-7/17/25. The document indicated Resident 4 had a 11.98% total weight loss from admission on [DATE] to the most recent weight on 7/31/25. The document indicated the facility did not predict, anticipate or implement timely or appropriate diet type interventions or identify potential nourishment factors that could lead to unintentional weight loss on admission or on the first signs of weight loss. During a review of Resident 4's Order Summary Report, dated 8/13/25, the document indicated, from 5/30/25-6/2/25 Resident 4 had a regular diet pureed texture thin consistency, from 6/2/25-6/9/25 Resident 4 had a regular diet minced and moist thin consistency, from 6/9/25-7/18/25 Resident had a regular diet mechanical soft texture thin consistency, from 7/18/25-8/7/25 Resident 4 had a fortified/high protein diet mechanical soft texture consistency to promote weight maintenance, and from 8/7/25- 8/13/25 Resident 4 had a fortified/high protein diet mechanical soft texture thin consistency. The document indicated Resident 4 had a 9.58% weight loss from 5/30/25-6/27/25 and on 7/1/25 diabetic snacks (healthy snacks that are low in added sugar) were added three times a day, in between meals related to significant weight loss and variable oral intake. The document indicated Resident 4 had a 14.37% weight loss from 5/30/25-7/17/25 and on 7/18/25 a fortified/high protein diet to promote weight maintenance and high protein nourishment two times a day were added for increased protein needs, on 7/21/25 additional snacks were added three times a day in between meals to promote increased oral intake. During a review of Resident 4's Nutrition Assessment, dated 6/16/25, the document indicated, .current food and fluid intake 51-75% .nutritional risk related to (proceed to care plan) variable PO [oral] intakes and at risk for malnutrition, CKD, metabolic encephalopathy[metabolic or chemical (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	imbalances in body], hypotension [low blood pressure], T2DM, PEM, dysphagia [difficulty swallowing], UTI [urinary tract infection-infection in urinary system], iron deficiency anemia, HTN [hypertension-high blood pressure], GERD [gastroesophageal reflux disorder- stomach acid flows back into esophagus]. During a review of Resident 4's IDT (interdisciplinary team) Weight Management Assessment, dated 6/27/25, the document indicated, Resident 4 had a significant weight loss in one week. The document indicated, .weight change likely r/t [related to] variable PO [oral] intakes.resident would benefit from weight maintenance/no further weight loss at this time. Dietary recommendations included adding diabetic snacks three times a day and to continue weekly weights. The document was signed by the Registered Dietician (RD). The document did not indicate the provider was in attendance. During a review of Resident 4's IDT Weight Management Update, dated 7/3/25, the document indicated, .weight update.weights: 07/03/2025: 149 lbs 06/27/2025: 151 lbs 06/19/2025 161 lbs weight change:18 lb (-10.7%) x1/mo [one month].meal consumption: 25-50% .Resident's current weight on 07/03/2025 in 149 lbs, reflecting a continued downward trend from 151 lbs on 06/27/2025 and 161 lbs on 06/19/2025.meal consumption remains variable, ranging between 25-50%. Resident is receiving 2 pm snack due to risk for malnutrition. Due to recent significant weight loss and inconsistent PO intake, dietary plan has been updated to included diabetic (DM-diabetic) snacks three times daily between meals. The document was signed by the RD. The document did not indicate an order for a 2 p.m. snack was placed. The document did not indicate the provider was in attendance. During a review of Resident 4's IDT Weight Management Update, dated 7/18/25, the document indicated, .weight update.weight variance.143lb.weight change 6 lb (-4%) x1/wk [one week].weight change likely [related to] variable PO intake. Resident with continued care presenting with significant weight loss x >3 month [greater than 3 months].resident would benefit from no further weight loss at this time.add fortified/high protein diet.add HPN [high protein] BID [twice a day]. The document was signed by the RD. The document did not indicate the provider was in attendance. During a review of Resident 4's IDT Weight Management Update, dated 7/24/25, the document indicated, .most recent weight on 07/24/2025 is 146 lbs, up from 143 lbs on 07/17/2025, and down from 149 lbs on 07/10/2025.resident has exhibited a pattern of gradual weight loss for over three months.continue to monitor trends. The document was signed by the RD. The document indicated Resident 4 had lost twenty-one pounds since admission on [DATE]. The document indicated once a high protein fortified diet and high protein nourishment shake were added on 7/18/25 Resident 4's weight improved. The document indicated Resident 4 was admitted with a protein calorie malnourishment and poor variable intake. The document indicated dietary inappropriately added snacks as a first intervention for a resident with decreased and variable intake. The document indicated Resident 4 was not appropriate assessed for nutritional needs. The document did not indicate the provider was in attendance. During a review of Resident 4's IDT Weight Management Update, dated 7/31/25, the document indicated, .weight update.weights: 07/30/2025: 147 lbs 07/24/2025: 146 lbs 07/17/2025: 143 lbs 07/10/2025: 149 lbs.will changed resident from weekly weights to monthly weights. The document was signed by the RD. The document did not indicate the provider was in attendance. The document did not trend the weight to the admission weight. During an interview on 8/8/25 at 11:10 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 4 did not have swallowing or chewing difficulties. CNA 2 stated she was not aware of any (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	swallowing or nutritional concerns for Resident 4. CNA 2 stated Resident 4 needed minimal assistance and ate meals in her room independently. During an interview on 8/8/25 at 11:15 a.m. with the Responsible Party (RP) 2, RP 2 stated he was Resident 4's husband. RP 2 stated he visited Resident 4 every day. RP 2 stated some days Resident 4 did not eat a lot. RP 2 stated facility staff weighed her frequently throughout the month. RP 2 stated he was not aware of her current weights or weight trend. During a concurrent interview and record review on 8/12/25 at 10:57 a.m. with the Speech Language Pathologist (SLP), Resident 4's Electronic Medical Record, dated 8/12/25 was reviewed. The SLP stated Resident 4 had been placed on his service since admission related to dysphagia and memory care. The SLP stated he had been working with Resident 4 to develop strategies and recall techniques to determine her least restrictive diet texture and encourage oral intake. The SLP stated Resident 4 did not currently have any swallowing or chewing issues. The SLP stated Resident 4 required encouragement with meal intake. The SLP stated he spoke with staff and had recommended meal encouragement when eating and distant supervision by eating in the vintage dining hall. The SLP stated there was no specific documentation of the recommendation or order for meal encouragement and dining in the vintage dining hall for distant supervision. The SLP stated he had changed Resident 4's diet texture throughout admission to determine the least restrictive diet texture and the Registered Dietician (RD) was responsible to determine the most appropriate diet type. The SLP stated dietary and clinical staff would refer residents to him for weight loss if there was a concern for swallowing or chewing. The SLP stated he had not received a weight loss referral for Resident 4. The SLP stated Resident 4 had a diet type order change on 7/18/25 to a fortified/high protein diet. The SLP stated from 5/30/25-6/27/25 Resident 4 had lost over 10 lbs, which was considered a significant weight loss. The SLP stated he had been aware of Resident 4's weight loss. The SLP stated a fortified/high protein diet should have been started immediately on admission or with noted significant weight loss. The SLP stated it was important to prevent weight loss and implement interventions before weight loss occurred or as soon as it was noted to have occurred. The SLP stated not initiating a fortified/high protein diet on admission or when first noting weight loss impacted Resident 4. During a concurrent interview and record review on 8/13/25 at 10:37 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 4's Electronic Medical Record, dated 8/13/25 was reviewed. LVN 3 stated Resident 4 weights had been down trending since admission with limited nutritional interventions. LVN 3 stated Resident 4 lost 20 lbs from 5/30/25 &ndash; 7/31/25 which was a significant weight loss. LVN 3 stated Resident 4 had poor and variable intake with an admitting diagnosis of protein-calorie malnourishment. LVN 3 stated it was not appropriate to add snacks as a nutritional intervention for a resident with poor or variable intake and significant weight loss. LVN 3 stated Resident 4 required fortified high protein nutritional supplements and diet types to ensure she received as many nutrients as possible when she did eat. LVN 3 stated Restorative Nursing Aides (RNA) were responsible to obtain weekly weights, report variances to licensed nursing staff and document weights. LVN 3 stated licensed nursing staff were responsible to trend weights once documented and notify nurse management to initiate interventions within the interdisciplinary team. LVN 3 stated licensed nursing staff were responsible for identifying weight variances and reporting weight changes to the provider. LVN 3 stated licensed nursing staff were responsible for reporting inappropriate dietary interventions to the unit manager and provider. LVN 3 stated Resident 4 was not an appropriate candidate to add dietary snacks with a documented poor oral intake. LVN 3 stated it was not appropriate for Resident 4 to be moved from weekly weights to monthly weights as she still had weight loss from admission. LVN 3 stated the RD was responsible to trend weekly weights. (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	During an interview on 8/13/25 at 11:13 a.m. with Restorative Nursing Aide (RNA) 1, RNA 1 stated RNA's obtained weekly weights, reported variances to licensed nursing staff , and documented weights. RNA 1 stated weekly weights were obtained to monitor for variance and initiate timely interventions before significant weight loss occurred. RNA 1 stated it was important to initiate person centered interventions to prevent and reverse weight loss. RNA 1 stated it was not appropriate to add snacks only as an intervention with noted poor intake and significant weight loss. RNA 1 stated protein and calories were needed to prevent weight loss such as shakes, supplements and protein. During an interview on 8/13/25 at 4:12 p.m. with the Registered Dietician (RD), the RD stated she was remote and had never been to the facility. The RD stated she shared the RD role with two other RD's. The RD stated she was responsible for managing residents with severe weight loss and attending weight loss interdisciplinary (IDT) meetings. The RD stated she could not view recorded weights within the electronic charting system. The RD stated she relied on the electronic charting system to alert her to significant weight changes at the intervals of one month, six months and one year. The RD stated that at three months she manually calculated weight changes. The RD stated she viewed weights at one-week intervals, but did not compare weekly weights to previous weeks' weights. The RD stated she would not compare trending weights until the one month, three-month, six months, and one year interval. The RD stated in IDT weight variance meetings, IDT members shared every residents trending weights since admission, but it was .overkill they tell me every weight trend and don't need to know. The RD stated, .I just look at weekly weights.wouldn't compare to the previous weeks weight or other recorded weights, at one month interval would trigger me if weight loss. The RD stated her first intervention was to always add snacks, unless the resident had poor intake then would suggest a nutritional supplemental diet intervention, such as a shake. The RD stated, .I wouldn't add all my interventions at once because then I wouldn't have anything else to try if they continued to lose weight. The RD stated Resident 4 was admitted with a protein-calorie malnutrition diagnosis with noted poor and variable intake. The RD stated she would not have initiated a fortified/high protein diet type on admission or with noted initial weight loss because .everyone comes in with a protein calorie malnourishment deficiency, why would I add everyone on that right away, everyone would be on a high protein fortified diet and high protein shakes then with that logic. The RD stated by adding snacks as an initial intervention with noted weight loss it increased Resident 4's opportunities to consume calories in between meals. The RD stated it was possible Resident 4 preferred to snack instead of eating meals. The RD could not state if Resident 4 preferred to snack instead of eating meals. The RD stated it was better to add snacks then to not have any interventions at all. The RD stated she completed nutritional assessments, remotely, and relied on licensed nursing staff to obtain information which she would then interpret and complete nutritional assessments. The RD stated there was a potential gap with the risk of delayed intervention by not comparing weekly weights to previous weeks and waiting for the one month, three-month, six months, and one year interval alert on the electronic charting system to trigger a weight change. The RD indicated by waiting for the one month, three month, six month and one year interval significant weight loss could occur without notice. During a concurrent interview and record review on 8/14/25 at 1:49 p.m. with the Director of Nursing (DON), Resident 4's Electronic Medical Record, dated 8/14/25 was reviewed. The DON stated resident weights were obtained on admission and then weekly for those at risk for weight changes. The DON stated weights were obtained weekly to identify potential weight variances. The DON stated it was important to trend all weights to identify weight changes before they became significant weight variances at one month, three-month, six month or one-year intervals. The DON stated it was important to trend weights so the IDT could conduct a weight variance meeting as soon as weight variances were identified. The DON stated the RD, licensed nursing staff, dietary staff, and herself (continued on next page)		

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F 0692 Level of Harm - Actual harm Residents Affected - Few	were present for IDT meetings. The DON did not state the provider attended IDT weight meetings. The DON stated the IDT meetings discussed trending weights as a team and then the RD provided recommendations and would consult with the provider for orders. The DON stated it was the responsibility of the RD to trend all weights since admission when performing weekly weight reviews and when participating in IDT meetings. The DON stated 180 days' worth of weights were discussed in weight IDT meetings to identify weight trends. The DON stated it would not be possible to identify a weight loss trend if all the weights were not compared. The DON stated Resident 4 had an admitting diagnosis of protein-calorie malnutrition and weight loss should have been anticipated. The DON stated Resident 4 should have been admitted on high protein shakes and a fortified high protein diet type to prevent weight loss based on her admitting diagnosis. The DON stated Resident 4 sustained a significant weight loss of 9.58% from 5/30/25-6/27/25. The DON stated it was not appropriate to solely add snacks as an intervention with significant weight loss and noted poor variable intake. The DON stated it was an expectation to add appetite stimulants, high protein shakes, and or fortified high protein diet types when significant weight loss was identified to prevent further weight loss. The DON stated it was expected and a standard of practice to add as many interventions as required to predict, prevent and reverse weight loss. The DON stated it was not appropriate to save interventions in anticipation of needing to add them for ongoing weight loss. The DON stated Resident 4 had delayed dietary interventions which led to further significant weight loss. The DON stated when weight loss is expected and identified dietary interventions should not be implemented one at a time. The DON stated by only viewing weekly weights and not trending weights there was a gap in the system. The DON stated the RD was expected, per policy and job duty description, to trend and monitor weights as to identify weight variances. The DON stated she was aware the RD relied on licensed nursing staff to obtain clinical assessment information for the RD to complete remote resident nutritional assessments. The DON stated it was unlikely the RD could complete effective and accurate nutritional assessments as she was not observing or collecting resident information herself. The DON stated ineffective and inaccurate nutritional assessments could contribute to weight loss. The DON stated it was not appropriate to allow Resident 4 to suffer weight loss before providing appropriate and timely nutritional interventions. The DON stated the RD withheld dietary interventions and delayed timely appropriate dietary interventions for Resident 4. The DON stated Resident 4 suffered unintentional weight loss which caused suffering and was determinantal to her well-being. The DON stated facility policy and procedures regarding weight loss and weight management had not been followed for Resident 4. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, dated 10/2017, the P&P indicated, .the dietician, nursing staff, and attending physician will regularly review the need for, and resident acceptance of,[TRUNCATED]		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of practice for nine out of 15 sampled residents (Residents' 95, 96, 14, 68, 86, 87, 129, 144 and 164) when:1.Resident 95's tramadol (opioid pain medication used to treat moderate to severe pain) medication lacked an appropriate indication and an associated pain scale to guide administration.This failure resulted in Resident 95's tramadol medication order not having complete and appropriate administration instructions which could lead to inappropriate administration, overmedication, or overdose. 2.Resident 96's oxygen therapy (a colorless, odorless, tasteless gas essential to living organisms) was not administered per the physician order. This failure resulted in Resident 32 not receiving his oxygen therapy as ordered which had the potential to result in nasal dryness, shortness of breath, oxygen toxicity (lung damage that happens from breathing in too much extra oxygen therapy), and serious medical condition.3. Licensed Vocational Nurse (LVN) 10 did not follow their facility protocol of responding to wander guard (a system designed to prevent residents in a healthcare facilities, particularly with dementia [a progressive state of decline in mental abilities] and Alzheimer's [a disease characterized by a progressive decline in mental abilities] from wandering off and potentially endangering themselves) alarm system when activated and turned off the alarm without checking outside of the facility for residents who could have possibly left the facility without staff knowledge.This failure placed Residents' 14, 68, 86, 87, 129 and 164 with wander guard at risk to have left the facility which could result in accidents and potential for serious injury.4. Resident 144's 8:00 a.m. scheduled 81 mg (milligram-a very small unit of weight) aspirin (medication used to help prevent heart problems because it keeps blood from clotting too easily), 100 mg extended-release (a type of medicine that released slowly into the body over time) metoprolol succinate (medication used to treat high blood pressure) and 10mg amlodipine (medication to treat high blood pressure) were administered at 9:12 a.m. These failures to follow proper medication administration practices had the potential to result in reduced effectiveness of treatment or harm to Resident 144.1.During a review of Resident 95'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 8/12/25, the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (condition in which brain tissue dies due to lack of blood flow), epilepsy (seizures due to abnormal brain activity), stiff-man syndrome (disorder which includes fluctuating muscle rigidity and spasms triggered by noise, touch, or distress), and major depressive disorder (persistent sadness). During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/22/25, the MDS indicated Resident 95 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 95 was cognitively intact. During a review of Resident 95's Order Summary Report, dated 8/12/25, the Order Summary Report indicated, .tramadol HCl oral tablet 50 MG (milligrams- unit of measurement for medication dosage) give 1 tablet by mouth every 8 hours for pain management.active.order date 5/23/24.start date 5/23/24. During an interview on 8/7/25 at 1:54 p.m. with Resident 95 in Resident 95's room, Resident 95 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated, licensed nursing staff administered tramadol every day. Resident 95 stated licensed nursing staff did not assess her pain prior to administration of tramadol. Resident 95 stated her pain was well controlled with her other medications and had acetaminophen (pain medication used to treat mild to moderate pain) available as needed if she had breakthrough pain, which worked to manage her pain. Resident 95 stated she had received tramadol every day since admission. Resident 95 stated she did not need pain medication everyday and would prefer not to take pain medication if she was not in pain. Resident 95 stated tramadol made her feel sleepy after administration. During an interview on 8/7/25 at 2:22 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 95 was able to make her needs known. CNA 1 stated Resident 95 did not often verbalize pain or show signs of being in pain. CNA 1 stated if Resident 95 was in pain she would notify the CNA or licensed nursing staff, and pain medication would be administered. During a concurrent interview and record review on 8/7/25 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 95's Order Summary and Medication Administration Record (MAR), dated 8/7/25 was reviewed. LVN 1 stated Resident 95 had an active order for tramadol to be given every 8 hours for pain management. LVN 1 stated Resident 95's tramadol medication order did not have an appropriate indication for use or associated pain scale within the administration instructions. LVN 1 stated it was important to ensure pain medication administration instructions had specific indications for use and associated pain scales to ensure the lowest most effective medication could be administered for pain management. LVN 1 stated routine, scheduled and as needed pain medication required pain scales associated within the order. LVN 1 stated tramadol was an opioid (a controlled substance that can become highly addictive) and would not be appropriate to be administered if Resident 95 had no pain. LVN 1 stated complete and appropriate administration instructions ensured medication was administered safely within parameters and could be monitored. LVN 1 stated without knowing what the pain medication was targeting to treat or what pain level to give it for it could not be assessed for effectiveness or tapered. LVN 1 stated Resident 95 was at risk for overmedication without complete and appropriate tramadol administration instructions. During an interview on 8/7/25 at 3:54 p.m. with Responsible Person (RP) 1, RP 1 stated she was Resident 95's medical and financial decision maker. RP 1 stated Resident 95 did not express or portray pain every day. RP 1 stated Resident 95 required pain medication to manage her diagnosis of stiff-man syndrome, but did not require pain medication every day. RP 1 stated some days Resident 95 had no pain. RP 1 stated Resident 95 was able to make her needs known and should be included in making her own medical decisions. During an interview on 8/12/25 at 3:45 p.m. with the Pharmacist Consultant (PC), the PC stated Resident 95's tramadol order administration instructions were not specific and required a review of her medical chart to determine appropriateness. The PC stated all pain medication orders required a pain scale within the administration instructions to ensure pain medication was administered appropriately. During a concurrent interview and record review on 8/14/25 at 1:49 p.m. with the Director of Nursing (DON) Resident 95's Order Summary Report, dated 8/14/25 was reviewed. The DON stated Resident 95's order for .tramadol HCl oral tablet 50 MG give 1 tablet by mouth every 8 hours for pain management. did not contain appropriate administration instructions. The DON stated pain medication needed to indicate what pain was being targeted to treat and an associated pain scale for administration. The DON stated pain can not be monitored if it is not known what the medication is being administered to treat or if it is not administered for an appropriate pain level. The DON stated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tramadol was an opioid that was intended to treat moderate to severe pain levels and would not be appropriate to administer for mild pain. The DON stated every pain medication is expected, per policy, to have an indication and reason as to why the medication was to be given. The DON stated it was important to understand what condition or pain symptom was being targeted for treatment to ensure monitoring and effective pain relief. The DON stated every pain medication was expected, per policy, to have an associated pain scale in the administration instructions to ensure it was appropriate to administer the medication for the targeted pain level. The DON said if pain medication was not administered appropriately it could lead to tolerance or dependency on the medication. The DON stated licensed nursing staff, and pharmacy was responsible to ensure all medications administration instructions were complete and accurate before administration. During a review of the facility's policy and procedure (P&P) titled, Administering Pain Medication, dated 10/2022, the P&P indicated, .facility wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.pain management is a multidisciplinary care process that includes.assessing the presence of pain.monitoring the effectiveness of interventions.when opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. During a review of the facility's in-service meeting minutes titled, Pain Level Monitoring and Documentation, dated 4/15/2025, the in-service meeting minutes indicated, if pain medication is ineffective or out of scale for pain medication notify MD immediately.example MAR.Norco 10/325 mg give 1 tablet by mouth every 4 hours as needed for severe pain level 7-10.entering (0) zero would be incorrect. 2.During a review of Resident 96's AR, dated 8/12/25, the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD-progressive lung disease that restricts breathing), acute and chronic respiratory failure (condition when lungs cannot oxygenate the blood), Alzheimer's disease (progressive disease that leads to cognitive decline and memory loss), and dementia (decline in mental ability). During a review of Resident 96's MDS, dated [DATE], the MDS indicated Resident 96 had a BIMS score of 15, which suggested Resident 96 was cognitively intact. During a review of Resident 96's Order Summary Report, dated 8/12/25, the Order Summary Report indicated, .oxygen at 2 liter/min [LPM- liter per minute- a unit of measurement for the flow rate of oxygen] via nasal cannula [a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen] as needed for shortness of breath.active.order start date 11/12/22.start date 11/12/22. and .oxygen at 2 liter/min via nasal cannula continuously at bedtime.active . order start date 11/12/22.start date 11/12/22 During an observation on 8/5/25 at 9:55 a.m. in Resident 96's room, Resident 96 was observed lying in bed, eyes closed with his nasal cannula in his nose. Resident 96's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents breathe). The oxygen concentrator was observed on the left side of the bed turned on at 4 LPM. During a concurrent observation, interview and record review on 8/6/25 at 8:11 a.m. with LVN 2 in Resident 96's room, Resident 96 was observed lying in bed with his nasal cannula in his nose. Resident 96's nasal cannula was observed connected to the oxygen concentrator. LVN 2 stated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 96's oxygen concentrator was on at 4 LPM. LVN 2 stated Resident 96 had an active oxygen order for 2 LPM as needed and at bedtime. LVN 2 stated Resident 96's oxygen concentrator should not be on 4 LPM. LVN 2 stated Resident 96's oxygen had not been administered correctly per physician order. LVN 2 stated licensed nursing staff were responsible for ensuring oxygen therapy was administered as prescribed. LVN 2 stated there was no documentation or order to reflect a rationale for the oxygen administration increase. LVN 2 stated oxygen was a medication and needed to be administered as prescribed. LVN 2 stated Resident 96 had COPD and was at risk for excessive oxygen administration which could result in serious medical conditions. During a concurrent interview and record review on 8/14/25 at 1:49 p.m. with the DON, a photo of Resident 96's oxygen concentrator, dated 8/5/25 and 8/6/25 and Resident 96's Order Summary Report, dated 8/14/25 was reviewed. The DON stated Resident 96 had an active order for oxygen therapy at 2 LPM via nasal cannula as needed for shortness of breath and oxygen therapy at 2 LPM via nasal cannula at bedtime. The DON stated Resident 96 received 4 LPM oxygen via nasal cannula on 8/5/25 and 8/6/25. The DON stated provider orders were not followed. The DON stated oxygen was a medication and she expected all licensed staff to administer medication per the provider order. The DON stated it was important to administer oxygen as ordered to ensure Resident 96's diagnoses were treated and maintained. The DON stated a new order and progress note would be required if oxygen was increased for any reason. The DON stated Resident 96 was at risk for oxygen toxicity and serious medical condition which could be detrimental to his care when the incorrect amount of oxygen was administered. The DON stated professional standards of practice, facility policy and procedure, and expectations were not followed when Resident 96 received the incorrect administration of 4 LPM oxygen therapy on 8/5/25 and 8/6/25. During a review of the facility's policy and procedure P&P titled, Administering Medications, dated 4/2023, the P&P indicated, medications are administered in accordance with prescriber orders.the individual administering the medication.verify.right dosage. if a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns. During a review of the facility's P&P titled, Oxygen Administration, dated 2/2024, the P&P indicated, .verify that there is a physician's order for this procedure. Review the physicians orders or facility protocol for oxygen administration.adjust the oxygen delivery device so that is comfortable for the resident and the proper flow of oxygen is being administered. During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . 3. During a concurrent observation and interview on 8/8/25 at 2:53 p.m. with LVN 10 in nursing station 1 and 2. LVN 7stated the alarm was set off by a resident with a wander guard. LVN 10 stated wander guard was also placed on residents trying to get out of bed without calling for assistance. LVN 10 stated all the facility doors are equipped with sensors and triggered when a resident with a wander guard gets too close to the door. LVN 10 stated the alarm in nursing station 1 & 2 was triggered by the double door that goes out to the parking lot. LVN 10 stated she turned off the alarm (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and did not check outside for any residents who may have left the facility. LVN 10 stated she was not sure about the facility protocol on turning off the alarm when triggered by a wander guard. LVN 10 stated she was not sure how many residents in her station had wander guard. During an interview on 8/12/25 at 8:26 a.m. with the Director of Staff Development (DSD), the DSD stated she started working in the facility on 5/22/25 and did not remember providing in-services training on elopement. The DSD stated the facility had six residents with a wander guard system. The DSD stated the facility practice was to check and look at the surrounding area, including outside of the facility and then turn off the alarm once cleared. The DSD stated once the alarm was triggered, staff should respond immediately. The DSD stated, Ensuring safety of residents is the priority. During a review of Resident 14's admission Record, dated 8/14/25, the admission record indicated Resident 14 was admitted to facility on 2/3/21 with diagnoses which included unspecified dementia and major depressive disorder (mental health condition characterized by feelings of sadness, loss of interest or pleasure). During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 14's Brief Interview of Mental status assessment (BIMS &ndash; assessment of cognitive status for memory and judgement) scored 7 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 14 had severe cognitive impairment. During a review of Resident 64's admission Record dated 8/14/25, the admission record indicated, Resident 64 was re-admitted to the facility on [DATE] with diagnoses which included dementia, muscle weakness and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) During a review of Resident 64's MDS assessment dated [DATE], the MDS assessment indicated Resident 64's BIMS score of 6 of 15 which indicated Resident 64 had severe cognitive impairment. During a review of Resident 86's admission Record, dated 8/14/25, the admission record indicated Resident 86 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), altered mental status (behaving or thinking differently than they usually do) and anxiety (feelings of worry, fear, nervousness, and unease). During a review of Resident 86's MDS assessment dated [DATE], the MDS assessment indicated Resident 86's BIMS score of 3 of 15 which indicated Resident 86 had severe cognitive impairment. During a Review of Resident 87's admission Record, dated 8/14/25, the admission record indicated Resident 87 was admitted to the facility on [DATE] with diagnoses which indicated unspecified dementia, depression and anxiety. During a review of Resident 87's MDS assessment dated [DATE], the MDS assessment indicated Resident 87's BIMS score of 12 out of 15 which indicated Resident 87 had moderate cognitive impairment. During a review of Resident 129's admission Record, dated 8/14/25, the admission record indicated, (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident 129 was admitted to the facility on [DATE] with diagnoses which included Parkinsonism (a progressive disorder of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement), dementia and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 129's MDS assessment dated [DATE], the MDS assessment indicated Resident 129's BIMS score of 3 of 15 which indicated Resident 129 had severe cognitive impairment. During a review of Resident 164's admission Assessment, dated 8/14/25, the admission assessment indicated, resident 164 was admitted to the facility on [DATE] with diagnoses which included dementia, muscle weakness and dysphagia oral phase (difficulty with the actions that happen in the mouth before the act of swallowing). During a review of Resident 164's MDS assessment dated [DATE], the MDS assessment indicated Resident 164's BIMS score of 3 of 15 which indicated Resident 164 had severe cognitive impairment. During an interview on 8/12/25 at 10:15 a.m. with Certified Nursing Assistant (CNA) 8, CNA 8 stated wander guard are used for residents who are at risk for elopement. CNA 8 stated when the door alarm was triggered by a wander guard, staff should immediately check outside the doors for any residents who may have left the facility without letting the staff know. CNA 8 stated the alarm stays on until all residents with wander guard are accounted for. During an interview on 8/12/25 at 2:05 p.m. with LVN 9, LVN 9 stated wander guard devices are placed on residents who are at risk for elopement. LVN 9 stated all the door leading to the outside have sensors and is triggered when a resident with a wander guard gets too close to the door. LVN 9 stated when an alarm goes off, the resident with a wander guard moved away from the door, check outside for any resident who may have left without staff knowing then turn off the alarm. LVN 9 stated, I do not just turn off the alarm asked staff to check the surroundings and check the locations of all residents with wander guard then turn off the alarm. During an interview on 8/13/25 at 10:59 a.m. with Registered Nurse (RN) 3, RN 3 stated the practice for when the wander guard alarm was triggered was to have staff check outside to make sure there were no residents trying to leave the facility. RN 3 stated some staff to check for residents with wander guard are all inside then turn off the alarm. During an interview with the Assistant Director of Nursing (ADON) the ADON stated wander are placed on residents are not alert and oriented and had history of wandering and tried to leave facility. The ADON stated the protocol for when the alarm was triggered was to assign staff to check outside of the facility and inside the facility to make sure residents did not try to leave facility without staff knowledge. The ADON stated once cleared and all residents accounted for then the alarm can be turned off. During an interview on 8/14/25 at 10:30 a.m. with the Director of Nursing (DON) the DON stated the expectation when a wander guard alarm was triggered was for staff to check outside the facility, resident rooms including toilet. The DON stated once cleared, the alarm can then be turned off. The DON stated, Accidents could happen if they are left outside. During an interview on 8/14/25 at 11:30 a.m. with the Administrator (ADM), the ADM stated, The practice was to get up and check to see if anyone get out. The ADM stated his expectation was for (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff to make rounds and check resident rooms to make sure no residents are missing. During a review of facility policy and procedure (P&P) titled, Resident Monitoring System, dated 3/23, the P&P indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. The Nurse, Social Services, or designee determines if resident needs to be placed on monitoring devise. Resident monitoring device are issued after obtaining physician's order and the resident or resident's authorized representative. Nursing will use the testing device provided by the manufacturer to ensure proper working order and document result. The Maintenance Department or designee tests the monitoring system at exit points at least weekly. document testing on the Monitoring Device testing log. During a review of facility policy and procedure (P&P) titled, Wandering and Elopement, dated 3/23, the P&P indicated, . If an employee observes a resident leaving the premises, he/she should: . get help from other staff members . instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave facility or has left the premises. If the resident is not located, notify the administrator and the director of nursing services, the resident's legal representative, the attending physician, law enforcement. 4. During a medication administration observation on 8/6/25 at 8:50 a.m. with LVN 6, LVN 6 entered a room, which was a three-resident room. LVN 6 administered the scheduled 9:00 a.m. medications to the residents in Bed A and Bed B. LVN 6 documented the medication administration as completed on the residents Medication Administration Record (MAR); the MAR screen at the time of administration were yellow. At 9:12 a.m., LVN 6 completed passing medications to Bed A and Bed B and proceeded to Resident 144 in Bed C. Resident 144's medications were scheduled for 8:00a.m. LVN 6 administered Resident 144 his scheduled 81 mg aspirin, 100 mg extended-release metoprolol succinate and 10 mg amlodipine. When LVN 6 documented the medications as administered in the MAR, the screen on the MAR was red/pink in color. The time of administration recorded in the medication administration task was 9:12 a.m. During an interview on 8/13/25 at 2:37 p.m. with the Pharmacy Consultant (PC), the PC stated staff have one hour before or one hour after the scheduled time to administer medications. The PC stated the nurse was outside of the allowed administration window by giving medications after 9:00a.m. The PC stated it was important for medications to be given within the scheduled time frame because delays could reduce their effectiveness and potentially cause complications in managing the residents' medical conditions. During an interview on 8/14/25 at 10:13 a.m. with LVN 4, LVN 4 stated medications were allowed to be administered one hour before or one hour after the scheduled time. LVN 4 stated if medications were given outside of that time frame, they were considered late. LVN 4 stated if the MAR screen was red the medication was considered late, and if the MAR screen was yellow, the medication was considered on time. LVN 4 stated a risk to the residents that medications might not be as effective if they were administered late. During an interview on 8/14/25 at 10:20 a.m. with LVN 6, LVN 6 stated there was a one-hour window to administer medications. LVN 6 stated if a medication was scheduled for 8:00 a.m. and was administered at 9:12 a.m. then the medication was administered late. LVN 6 stated it was important that medications were given on time because they managed chronic conditions and delays in administration could cause complications. (continued on next page)		

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 8/14/25 at 10:59 a.m. with the DON, the DON stated nursing staff could administer medications either one hour before or one hour after the scheduled time. The DON stated if medications were given outside of that time frame, they were considered late, and that it was considered a medication error. During a review of the facilities P&P titled, Administering Medications, revised April 2023, staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. medications are administered in accordance with prescriber orders, including any required time frame. medication administration time are determined by resident need and benefit. medications are administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review the facility failed to ensure food reached an appetizing temperature when temperatures for gravy sauce, french fries, grounded burger patty, food in cups and diced pears did not reach desired temperatures during tray line on 8/6/25. This failure placed all residents receiving food from the kitchen not eating their meal and placed their nutritional status at risk which could potentially lead to weight loss. Facility During on observation on 8/6/25 between 11:30 a.m. through 12:45 p.m. in the kitchen during tray line, observed dietary cook (DC) and DC 2 checked temperatures of the food on the steam table. Temperature of french fries, gravy sauce, grounded burger patty, food in cups and diced pears were not checked. During an interview on 8/8/25 at 9:24 a.m. with DC 1, DC 1 stated the practice was to make sure temperatures of food on the steam table including desserts were checked to ensure the was safe to serve residents. DC 1 stated food temperatures are checked prior to serving and document in the logbook every meal. DC 2 stated it was the responsibility of the cook to ensure the temperature of food reached a safe temperature to serve to residents. DC 1 stated there was a risk of residents getting sick if the temperature of food was not safe. DC 1 stated residents could get sick. During an interview on 8/8/25 at 10:20 a.m. with Certified Dietary Manager/Driver (CDM/D), he stated it was important to check temperatures of all the food making sure it reached a safe temperature prior to serving to residents. The CDM/D stated his expectation was to make sure temperatures of food were checked and recorded in the logbook. The CDM/D stated not checking temperature could result in undercooked food which could place residents to develop gastrointestinal illness (illness that affects the digestive system [GI tract] which runs from mouth to anus) which could result in serious health condition. During an interview on 8/12/25 at 9:27 a.m. with Certified Dietary Manager Assistant (CDMA), she stated all temperatures of food to be served to residents should be checked and that included dessert. The CDMA stated the cook usually are responsible for ensuring the temperatures are checked and documented. During a phone interview on 8/12/25 at 4:21 p.m. with the Registered Dietitian (RD), the RD stated her expectation was, All food in the hot table needs temperature to be checked. The RD stated checking the temperature to ensure food was safe to serve to residents. The RD stated unsafe temperatures could cause serious illnesses for residents. During a review of facility's policy and procedure (P&P), titled, Food Preparation and Service, dated 10/17, the P&P indicated, .The danger zone for food temperatures is between 41 degrees Fahrenheit [unit of measurement] and 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms [tiny living organism that can cause disease or illness] that cause foodborne illness [disease of discomfort caused by consuming contaminated food or beverage] . The longer foods remain in the danger zone the greater the risk for growth of harmful pathogens.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the planned menus were followed when residents on fortified diet (foods that have extra nutrients, like vitamins and minerals to improve the food's nutritional value to prevent nutrient deficiencies) were not served fortified food as prescribed by their Medical Doctor (MD) on 8/6/25. This failure had the potential for all residents on fortified diets to receive inadequate amounts of nutrients, potentially leading to weight loss and malnutrition. During review of facility's document titled, WEEK 2 WEDNESDAY Cambridge [NAME] CYCLE 2 2025 Spring, undated, the document indicated, . Lunch. FORTIFIED HIGH PROTEIN. SUPER SOUP 6 oz [ounces-unit of measurement]. During observation on 8/6/25 between 11:48 a.m. to 12:45 p.m. during the tray line, dietary staff scooped food in plates for residents, different diet types were observed, fortified diet were prepared like other diets. Dietary staff did not add fortified soup to the food trays for residents ordered a fortified diet. During an interview on 8/8/25 at 9:45 a.m. with Dietary [NAME] (DC) 1, she stated it was important to make sure residents on fortified diet received their diet as ordered by MD. DK 1 stated fortified diet are ordered for residents who are at risk for losing weight. DK 1 stated dietary staff serving the food should make sure to give residents the fortified diet to prevent additional weight loss. During a concurrent interview and record review on 8/8/25 at 10:35 a.m. with Certified Dietary Manager/Driver (CDM/D), CDM/D reviewed the menu spread sheet for 8/6/25 and stated residents on fortified diet should have received six ounces super soup for lunch. The CDM/D stated residents on fortified diet needed the extra calories on their meal to prevent them from losing more weight. The CDM/D stated dietary staff should have made sure residents received their fortified diet as ordered by MD. During an interview on 8/12/25 at 9:40 a.m. with Certified Dietary Manager Assistant (CDMA), the CDMA stated residents on fortified diet did not receive fortified food on 8/6/25 for lunch. The CDMA stated it was important to follow diet ordered by MD because residents needed extra calorie and protein. During a phone interview on 8/12/25 at 4:15 p.m. with Registered Dietitian (RD), the RD stated it was important to ensure residents on fortified diet received the diet ordered by the MD. The RD stated her first recommendation for residents who are losing weight was to give fortified food to stop the weight loss and gain weight back. The RD stated it was important to follow a fortified diet as ordered by MD. During a review of facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 10/17, the P&P indicated, .Food and nutrition services staff will inspect food trays to ensure the correct meal is provided to each resident, the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature. a. If an incorrect meal is provided to a resident, or a meal does not appear palatable, nursing staff will report it to the Food Service Manager so that a new food can be issued. During a review of the facility's policy and procedures (P&P) titled, Therapeutic Diets, dated 10/17, the P&P indicated, .1. Diet will be determined in accordance with the residents' informed choices, preferences, treatment goals and wishes. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The physician may delegate this task to a registered dietitian as permitted by state law. 4. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare food in accordance with professional standards for food services safety when:1.One of two ice machines and food preparation sink was not equipped with an air gap (a vertical space between the end of a pipe and the top of a nearby sink that prevents the backflow of contaminated water).This failure had the potential for contaminated water to flow back into the sink and ice machine and result in pathogenic (viruses, bacteria and other types of germs that can cause disease) microorganism (an organism that is so small it can only be viewed under a microscope) growth that could inadvertently (accidentally) be transferred to food and served to 173 residents in the facility, causing foodborne illness.2.Two opened bags of parmesan cheese and one and one-half loaves of bread did not have an opened or used by date.3. One dietary staff member did not cover all her hair on the sides with her hair net while working inside the kitchen.4. Food scoops used for puree diet were laid on top of the steam table during tray line. These failures had the potential for residents to develop gastrointestinal illness (illness that affects the digestive system [GI tract] which runs from mouth to anus) which could result in serious health conditions.1. During a concurrent observation and interview on 8/6/25 at 8:50 a.m. in the kitchen with Certified Dietary Manager/Driver (CDM/D) and Certified Dietary Manager Assistant (CDMA), checked the ice machine in the kitchen and the food preparation sink did not have an air gap. The CDMA stated they need an air gap to prevent backflow of contaminated water to the machine and the food preparation sink and preventing bacteria from going into the food to be served to residents. The CDM/D stated he will let the administrator know to work on the air gap.During an interview on 8/8/25 at 10:07 a.m. with CDM/D, the CDM/D stated he contacted a company to inspect and install an air gap. The CDM/D stated air gap prevents the overflow of contaminated water back in the food preparation sink. CDM/D stated residents served contaminated food and ice water could make them sick, especially our vulnerable residents. The CDM/D stated the ice machine in the kitchen did not have an air gap and he tried to put one after the service guy completed the service on the machine. During an interview on 8/12/25 at 9:20 a.m. with the CDMA, the CDMS stated the air gap was important to prevent overflow back to the ice machine and the food prep sink preventing contaminated water and bacteria from getting in the water and food served to residents. The CDMA stated they serve a vulnerable population and serving them contaminated water and food could easily make them sick which could lead to serious health condition.During a review of the professional reference titled, FDA Food Code 2022, Chapter 5. Water, Plumbing, and Waste, section 5-203.14 indicated, . A PLUMBING SYSTEM shall be installed to preclude backflow of a solid, liquid, or gas contaminant into the water supply system at each point of use at the FOOD ESTABLISHMENT . backflow prevention is required by LAW, by: . providing an air gap as specified under S 5-202.13 . During a review of professional reference titled, FDA Food Code 2022 Annex 3. Public Health Reasons/Administrative Guidelines, section 5-202.13 indicated, . During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system. Standing water in sinks, dipper wells, steam kettles, and other equipment may become contaminated with cleaning chemicals or food residue . Providing an air gap between the water supply outlet and the flood level rim of a plumbing fixture or equipment prevents contamination that may be caused by backflow . 2. During the initial tour in the kitchen on 8/5/25 at 9:15 a.m. with CDM/D, two opened bags of parmesan cheese found with no opened date and used by date. One and one-half loaves of bread were found under the food preparation sink and had no opened or used by date.During an interview on 8/8/25 at 9L24 a.m. with Dietary [NAME] (DC) 1, DC 1 stated the bread should not have been moved from the rack and stored under the sink and should have been labeled with the date it was opened and used by date. DC 1 stated the parmesan (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cheese should have been dated also with the opened and used by date. DC 1 stated it was important to have the dates to make sure food was not served to residents past its used by date. During an interview on 8/8/25 at 10:15 a.m. with the CDM/D, he stated her expectation was for all opened food to be labeled with the date opened and used by date. The CDM/D stated dietary staff should have made sure they labeled everything they opened to prevent serving expired food to residents, which could make them sick. During a review of the facility policy and procedure (P&P) titled, Refrigerators and Freezers, dated 12/14, the P&P indicated, . All food shall be appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) will be marked on cases and on individual items removed from cases for storage. Use by dates will be completed with expiration dates on all prepared food in the refrigerator. Expiration dates on unopened food will be observed and use by dates indicated once food is opened. 3. During an interview on 8/8/25 at 9:30 a.m. with DC 1, she stated everyone working in the kitchen should be wearing hair nets appropriately and to make sure there are no loose hair outside of the hair net. DC 1 stated hairnet prevents hair from falling in the plate served to residents. DC 1 stated it was a contamination issue; we do not want residents to get sick when we can prevent it. During an interview on 8/8/25 at 10:15 a.m. with CDM/D, he stated the expectation was for anyone entering the kitchen to the food preparation area to wear a hairnet and to ensure all hair was covered. The CDM/D stated men who have beard and worked in the kitchen are also expected to cover their beard. The CDM/D stated this was to prevent cross contamination of food served to residents which could make them sick. During an interview on 8/12/25 at 9:30 a.m. with CDMA, she stated she started working for the company 4/25. CDMA stated the expectation was to make sure all dietary staff wear hairnet as soon as they enter the kitchen and to ensure all the hair was covered, no loose hair. The CDMA stated covering hair was to prevent hair from falling into the food which could cause contamination. During a review of facility policy and procedure (P&P) titled, Food Service Distribution, dated 10/17, the P&P indicated, . 7. Food and nutrition services shall wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food. During a review of the facility policy and procedure (P&P) titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, dated 12/21, the P&P indicated, . Food Service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens. 4. During tray line observation on 8/6/25 at 11:30 a.m. observed DK 2 by pureed food with scoops laid out on top of the steam table next to the pureed food trays. Observed DK 2 placed the food scoops on top of the steam table after each used. The scoops had food left over and left food particles on top of the steam table. During an interview on 8/8/25 at 9:35 a.m. with DC 1, she stated the food scoops for the pureed food should have been left inside the food tray. DK 1 stated placing the scoops on top of the steam table after each used was not acceptable and unsanitary. DC 1 stated it could cause cross contamination which could cause residents to get sick. During an interview on 8/8/25 at 10:35 a.m. with CDM/D, he stated it was not acceptable to place the scoops on top of the steam table. The scoop had left over food on it and leaving food on top of the steam table every time the scoop was used. CDM/D stated it was a contamination issue which could cause illness to residents. During an interview on 8/8/25 at 10:55 a.m. with the DC 2, DC 2 stated she served the puree food during the tray line. DC 2 stated she placed the food scoops on top of the steam table after each use. DC 2 stated she should have left the scoops inside the food tray and not placed them on top of the steam table next to the pureed food. DC 2 stated it was unsanitary; there could have been bacteria which could have made residents sick. During a phone interview on 8/12/25 at 4:03 p.m. with the Registered Dietitian (RD), the RD stated she had not been in the facility, she lives five hours away from the facility and her contract was for her to work remotely. The RD stated there are other RD's contracted with the facility who does the on-site visit. The RD stated she had never seen or heard of the word airgap before, the RD stated, It is a new terminology to me. The RD stated the expectation was for all food in the steam/hot table (continued on next page)		

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Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature checked to ensure food reached the proper temperature and safe to serve to residents. The RD stated her expectation as an RD was to ensure fortified diet was followed. The RD stated her first recommendation for residents who are losing weight was to fortify the diet. The RD stated staff working in the kitchen should be putting on the hairnet and beard for men as soon as they enter the kitchen and to ensure all the hair was covered and no loose hair. The RD stated the hairnet and beard cover was to prevent any loose hair falling on the food served to residents which is an infection control issue. During a review of the facility policy and procedure (P&P) titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, dated 12/21, the P&P indicated, . Food Service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interview and record review, the facility failed to conduct a facility wide assessment specific to the facility needs when:The facility did not include an evaluation of the physical environment in its facility assessment to ensure the needs of the resident population were met for 26 of 26 residents in the memory care unit and 15 of 15 smokers in the facility. These failures placed residents in the memory care unit unable to exit the door in an emergency and could lead to entrapment and placed smoking residents safety at risk. During a concurrent interview on 08/14/2025 at 3:25 p.m. with the Administrator (ADM) and the Director of Nursing (DON), the DON stated they did not identify any issues with how the Resident smoking area was set up in the past. The ADM stated they implemented changes after a resident was hit by a vehicle, but nothing was documented in the facility assessment. The ADM stated they felt no need to assess issues with the smoking area because they had not had an accident before. The ADM stated the facility assessment was not updated for the lock placed on the door in the memory care unit. The DON stated she had toured the unit before with another health facilities evaluator nurse and no issues with the lock were identified. The ADM stated the last time the Facility Assessment was updated was on may 2nd 2025 but it was not updated to reflect the smoking area or the locked door in the memory care unit. During a review of the facility's Facility Assessment, undated, the Facility assessment did not include any assessments regarding safety in resident smoking areas or environmental assessments regarding locks on doors in the memory care unit.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect and promote the rights of the residents for 13 of 28 sampled residents (Residents' 2, 14, 30, 148, 38 50, 4, 9, 28, 59, 67, 68 and 130) when: 1a. Staff did not use an alternate communication method with Spanish speaking residents (Residents 2 and 14) such as language assistance, interpreters or translated materials. 1b. Staff was speaking in a foreign language during resident care for Residents 30, 148, 38 and 50. These failures violated Residents 2, 14, 30, 148, 38 and 50's rights to understand the care provided to them in a language they understood. 2. Three female residents in room [ROOM NUMBER] shared a bathroom with three male residents in room [ROOM NUMBER]. 3. Resident 4 watched other residents on her table eating while she waited for over five minutes for her food to be delivered on 8/5/25. These failures resulted in violation of Resident's 4, 9, 28, 59, 67, 68 and 130's right to privacy and dignity. 1. During an interview on 8/6/25 at 9:30 a.m. with Resident 2 and her daughter, Responsible Party (RP) 4, RP 4 stated Resident 2 speaks Spanish and understood very limited English. RP 4 stated Resident 2 relied on pointing a lot. Resident 2 demonstrated that she can say, I need a pain pill in English. There were no alternate communication method observed in Resident 2's room. RP 4 stated it was a challenge and difficulty when there are no Spanish speaking staff assigned to care for Resident 2. During an interview on 8/6/25 at 3:47 p.m., with Resident 14, Resident 14 stated in Spanish he could not speak English. There were no alternate communication methods observed in Resident 14's room. Resident 14 stated to Certified Nursing Assistant (CNA) 2 who came into the room that it would be helpful with his care needs being met if there was a board with pictures on it so he could point out to staff if he needs something. CNA 2 stated she was not proficient in speaking and interpreting medical terminology in Spanish and would not understand Resident 14 if he verbalized a medical need. During an interview on 8/5/25 at 10:20 a.m., with Resident 30, Resident 30 stated he has difficulty verbalizing his needs and understanding some staff because they were talking in a foreign language while providing care to him. During an interview on 8/5/25 at 10:43 a.m., with Resident 148 stated staff were speaking in a foreign language during care. During an interview on 8/5/25 at 11 a.m., with Resident 38, Resident 38 stated staff were speaking in a foreign language while providing care to her and her roommate During an interview on 8/5/25, at 12:15 p.m., with Resident 50, Resident 50 stated she had the same complaints with her roommate as some staff were speaking in a foreign language while providing care to them. Resident 50 stated it was frustrating to not understand what the staff were saying while providing care to her. During a concurrent interview on 8/5/25 at 2:17 p.m., with the Director of Nursing (DON), the DON reviewed the staffing schedules the week of 7/21/25 to 7/27/25. The DON stated the expectation was for staff not to speak in a foreign language while providing care to the resident. The DON stated staff should be speaking in a language understood by the residents in order to have the residents needs met. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/25 at 10:19 AM with Registered Nurse 2 (RN 2), RN 2 was unable to articulate interventions she would put in place for Spanish speaking residents. During an interview on 8/13/25, at 1:36 p.m., with Licensed Vocational (LVN) 4, LVN 4 stated she would ask Spanish speaking staff to translate for her when communicating with Spanish speaking residents. LVN 4 stated she was not aware of translator services available in the facility. During an interview on 8/13/25, at 11:14 a.m., with LVN 3, LVN 3 stated she was not proficient in speaking Spanish to Spanish speaking resident and would need a translator. LVN 3 stated residents would have difficulty if staff spoke in a foreign language during care and it was important for staff to speak in a language residents could understand to provide their care needs. During an interview on 8/13/25 at 1:58 p.m., with the DON, the DON stated Spanish speaking staff were not available 24/7 and the expectation was to have a communication board, or a language line staff can use. The DON stated she has been in the facility for two a half months and she has not seen any communication board or language line being utilized by the staff. During a review of the facility's policy and procedure titled, Communication Barriers, Reduction of, with a revised date of 11/8/17, indicated, .the facility will make arrangements for interpreters or alternate means of communication such as pictures, sign language, Braille, etc., to enhance communication between residents and staff During a review of job description for Certified Nurse Assistant (undated) indicated as a requirement that the staff member, .must be able to speak, read, write and comprehend the English language . During a review of job description for Charge Nurse (undated) indicated as a requirement that the staff member, .must be able to speak, read, write and comprehend the English language . During a review of job description for Registered Nurse Supervisor (undated) indicated as a requirement that the staff member, .must be able to speak, read, write and comprehend the English language . During a review of the facility's policy and procedure titled Resident Rights, with a revised date of February 2023, indicated that the, .residents have the right to be treated with respect, kindness, and dignity. 2. During an observation on 8/7/25 at 2:20 p.m. in hallway outside of room [ROOM NUMBER] and 17. room [ROOM NUMBER] had three female residents and room [ROOM NUMBER] had three male residents. room [ROOM NUMBER] and room [ROOM NUMBER] had one bathroom located between rooms towards the end of the room, one door leading to room [ROOM NUMBER] and one room leading to room [ROOM NUMBER]. During a review of Resident 9's admission Record, dated 8/8/25, the admission record indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and dementia (a progressive state of decline in mental abilities). During a review of Resident 59's admission Record, dated 8/13/25, the admission record indicated Resident 59 was admitted to the facility on [DATE] with diagnoses which included dementia and (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	multiple sclerosis (a disease that causes breakdown of the protective covering of the nerves). During a review of Resident 67's admission Record, dated 8/8/25, the admission record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses which included depression (persistent feelings of sadness, hopelessness, and loss of interest in activities that were once enjoyable) and hallucination (experiencing something, such as a sound, sight, smell, taste, or touch, that is not actually there yet it feels real). During a review of Resident 28's admission Record, dated 8/13/25, the admission record indicated Resident 28 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD- irreversible kidney failure) and pain. During a review of Resident 68's admission Record, dated 8/13/25, the admission record indicated Resident 68 was admitted to the facility on [DATE] with diagnoses which included dementia and muscle weakness. During a review of Resident 130's admission Record, dated 8/13/25, the admission record indicated Resident 130 was admitted to the facility on [DATE] with diagnoses which included heart failure (heart muscle cannot pump enough blood to meet the body's need) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) During a concurrent interview and record review on 8/12/25 at 11:45 a.m. with the Director of Staff Development (DSD), the DSD reviewed resident room assignments and stated room [ROOM NUMBER] are all female residents and room [ROOM NUMBER] are all male residents and stated, They should not have shared bathroom. The DSD stated room with male residents only should not be sharing bathroom with a room with female residents. The DSD stated, Privacy is one of the patient rights. During a concurrent observation and interview on 8/12/25 at 10:15 a.m. with CNA 8, CNA 8 walked to room [ROOM NUMBER] and room [ROOM NUMBER]' bathroom and stated, both resident rooms shared one bathroom, the facility should not be doing it CNA 8 stated she was familiar with residents in room [ROOM NUMBER] and room [ROOM NUMBER]. CNA 8 stated Resident 28 was ambulatory and was the only resident using the bathroom. During an interview on 8/12/25 at 10:51 a.m. with CNA 7, CNA 7 stated social service department are responsible in making the decision of moving residents, they decide what room they are moved to. CNA 7 stated not sure how long residents had been in room [ROOM NUMBER] and room [ROOM NUMBER], they had been in their room for a while. During an interview on 8/13/25 at 9:15 a.m. with the Social Service Director (SSD), the SSD stated the social service department handles moving residents to different rooms and ensures compatibility of residents. The SSD stated she barely started in the facility as the SSD, and she was not aware of the situation in room [ROOM NUMBER] and room [ROOM NUMBER] sharing bathroom. The SSD stated the practice was to notify family members of residents before moving to a different room. The SSD stated she was not sure whether families of residents in room [ROOM NUMBER] and 17 were notified of the situation. The SSD stated it was resident rights to not share a bathroom with the opposite sex. During a phone interview on 8/13/25 at 10:17 a.m. with RP 5, RP 5 stated it was her first time to hear about her family member (Resident 59 in room [ROOM NUMBER]) room sharing a bathroom with male (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. RP 5 stated she was concerned because Resident 59 would tell her things and she was not sure of the facts. RP 5 stated she hopes the facility will do something about the situation. During a phone interview on 8/13/25 at 10:29 a.m. with RP 6, RP 6 stated he was not aware her family member's (Resident 67 in room [ROOM NUMBER]) room was sharing a bathroom with a room with male residents. During a phone interview on 8/13/25 at 11:39 a.m. with RP 7, RP 7 stated he was not aware of his family member (Resident 68 in room [ROOM NUMBER]) sharing a bathroom with a room with female residents. RP 7 stated it was not acceptable for both rooms to share one bathroom even if none of the residents in room [ROOM NUMBER] did not use the bathroom. RP 7 stated the facility did not inform him of the situation. During an interview on 8/14/25 at 10:29 a.m. with the DON, the DON stated, There should be separation of male and female residents. The DON stated female and male residents can not share a bathroom, it is one of their resident rights to have privacy. During an interview on 8/14/25 at 11:25 a.m. with the Administrator (ADM), the ADM stated room [ROOM NUMBER] and room [ROOM NUMBER] sharing a bathroom is a nursing issue. The ADM stated he needed to investigate the situation and who are the residents in the room who can use the bathroom. The ADM stated, I do not have to answer to that, I have to find who can answer, when asked if families of affected residents were made aware of the situation. During a review of facility policy and procedure (P&P) titled, Resident Rights, dated 2/23, the P&P indicated, .Federal and Stated laws guarantee certain basic rights to all residents of this facility. These rights include .a dignified existence, be treated with respect, kindness and dignity, be free from abuse, neglect.be informed of safety or clinical restrictions. During a review of facility's policy and procedure (P&P) titled, Transfer, Room to Room, dated 12/16, the P&P indicated, .The facility reserve the right to make room transfers when necessary and as may be requested by the resident, an/or his or her representative (sponsor). Orient the resident to the new transfer. his or her family and visitors will be informed of the room change. 3. During observation on 8/5/25 at 12:05 p.m. in the dining room between 12:05 p.m. to 12:25 p.m. Resident 4 was observed sitting on one table with three other residents. Facility staff started distributing food to residents in the dining room. Staff served food to other residents at Resident 4's table at 12:15 p.m. and they started eating while Resident 4 watched while waiting for her food. Resident 4's food was served at 12:25 p.m. During an interview on 8/5/25 at 12:20 p.m. with CNA 10 in the dining room assisting a resident at Resident 4's table. CNA 10 stated one of the staff went in the kitchen to follow up on Resident 4's food. CNA 10 stated she was not sure why the kitchen did not send Resident 4's food tray in the cart with the other resident's food tray. CNA 10 stated it was not right for Resident 4 watching other residents eat while she was waiting for her food. During an interview on 8/12/25 at 11:45 a.m. with the Director of Staff Development (DSD), the DSD stated the during meals, staff should be making sure to let the kitchen know where residents will be eating to avoid residents watching other residents eat while waiting for their food. The DSD stated it was a dignity issue and resident rights. (continued on next page)		

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/12/25 at 10:46 a.m. with CNA 7, she stated during mealtimes, licensed nurse checked the food in the cart before it was distributed to residents. CNA 7 stated food is served at one table at a time to avoid having residents watching other residents on their table eat while they wait for their food. CNA 7 stated she was not sure why Resident 4's tray was late; she usually eats in the dining room. CAN 7 stated Resident 4 should not have to watch other residents at her table while she waited for her food. During an interview on 8/14/25 at 10:25 a.m. with the DON, the DON stated the staff should have made sure to notify kitchen of residents eating in the dining room to avoid having residents watched other residents eat while they wait for their food. The DON stated the practice was to serve one table at a time. During a review of facility policy and procedure (P&P) titled, Assistance with Meals, dated 7/17, the P&P indicated, . All residents will be encouraged to eat in the dining room. Facility staff will help resident who require assistance with eating. The Food Services Department will deliver food carts to appropriate areas. During a review of facility policy and procedure (P&P) titled, Resident Rights, dated 2/23, the P&P indicated, .Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include .a dignified existence, be treated with respect, kindness and dignity, be free from abuse, neglect.be informed of safety or clinical restrictions.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for four of 22 sampled residents (Resident 6, 49, 68 and 185), when1. Resident 6's care plan interventions to minimize fall related injuries were not implemented. Resident 6 did not have a bilateral floor mat and reacher at bedside. This failure had the potential to place Resident 6 at risk for an avoidable fall and obtaining fall-related injuries. 2. Resident 49's care plan interventions to address communication problem related to diagnosis of Expressive Aphasia (a disorder that makes it difficult to speak) and Resident 49's primary language was Persian were not implemented. Resident 49 had no communication book and/or translator/interpreter service. This failure resulted in Resident 49 getting frustrated about not being able to communicate with the staff and being understood by staff. 3. Resident 68's care plan interventions to provide his prescribed diet and a scoop plate (an assistive plate which helps people place food on their utensils) were not followed. This failure had the potential to cause resident 68 to not be able to adequately scoop up his own food and also cause Resident 68 to choke on food not prepared in accordance with his diet order 4. Resident 185's care plan interventions indicated the bed was to remain in the lowest position to reduce the risk for falls. The bed was observed not in the lowest position. This failure had the potential to place Resident 185 at an increased risk for fall and injury.1. During a concurrent observation and interview on 8/7/2025 at 10:12 a.m. with Resident 6, in Resident 6's room, Resident 6 was sitting in wheelchair awake, clean and well groomed. Resident 6 had a floor mat (a cushioned floor pad designed to help prevent injury should a person fall) against the wall. Resident 6's wife and daughter were at bedside. Resident 6 was alert and oriented to familiar names and faces including his name and the names of his wife and daughter. Resident 6 stated he had fallen from bed. During an interview on 8/7/2025 at 10:14 a.m. with Responsible Person (RP) 3, in Resident's 6's room, RP 3 stated Resident 6 had been falling from bed at the facility and was witnessed by his roommate. RP 3 stated Resident 6 had a Urinary Tract Infection (UTI- an infection in the bladder/urinary tract) and had confusion (inability to think clearly or quickly, often resulting in disorientation). RP 3 stated Resident 6 attempted to get out of bed and stand from his wheelchair. RP 3 stated she visits every day to closely monitor Resident 6. RP 3 stated Resident 6 had one floor mat in the room and should have two floor mats for each side of bed. She stated Resident 6 was receiving therapy. During a review of Resident 6'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 8/8/25, the AR indicated Resident 6 was admitted to the facility on [DATE] with primary admitting diagnosis of Sepsis (a life-threatening blood infection). Resident 6 had other diagnosis of Peripheral Vascular Disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), Encephalopathy (a condition that alters brain function or structure, leading to change in mental status), Essential Hypertension (HTN-high blood pressure), Anemia (a condition where the body does not have enough healthy red blood cells), and muscle weakness. During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/22/24, the MDS section C indicated Resident 6 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 8 (a score of 0-7 (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was moderately impaired. During an interview on 8/07/2025 at 3:19 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated Resident 6 was a high risk for falls due to multiple attempts of getting out of bed and getting up from his wheelchair. CNA 4 stated Resident 6's confusion had increased. CNA 4 stated she saw one floor mat in Resident 6's room and she had not seen a Reacher (a daily living aid designed to assist people with limited range of motion to grab out of reach items with ease) at bedside. CNA 4 stated Resident 6 should have a falling star at his name by the door. CNA 4 stated Resident 6 requires assistance with activities of daily living (ADLs - routine tasks/activities such as transferring from bed to wheelchair/wheelchair to bed, bathing, dressing and toileting a person performs daily to care for themselves). CNA 4 stated Resident 6's care plan should be followed by staff to prevent Resident 6 from falling. CNA 4 stated the care plan should be reviewed by staff at the beginning of the shift for staff to follow to ensure proper care is being provided to the residents. During a concurrent interview and record review on 8/08/2025 at 2:15 p.m. with the Director of Nursing (DON), Resident 6's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, .The resident is at risk for falls with injury related to limited mobility, use of antihypertensive medication (a type of drug used to treat high blood pressure), altered mental status.Interventions: Floor mat to right side and left side of bed to minimize the risk of injury from falls. Provide Reacher to the resident. The DON stated Resident 6 should have two floor mats for right and left side of bed and reacher should be placed within easy reach. The DON stated fall care plan interventions should be implemented and followed to achieve the goal of preventing more falls and minimizing fall related injuries. During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person Centered, revised March 2023, the P&P indicated, . 3. The care plan intervention is derived from analysis of the information gathered as part of the comprehensive assessment.7. the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; c. includes the resident's stated goals upon admission and desired outcomes.reflects currently recognized standards of practice for problem areas and conditions. 2. During a concurrent observation and interview on 8/5/2025 at 11:02 a.m. with Resident 49, in Resident 49's room, Resident 49 was lying in bed. Resident 49 was awake with slurred (indistinct and difficult to hear or understand) speech and was able to respond during conversation by nodding his head using yes and no questions. Resident stated dadada.tatatata. continuously. Resident 49 was unable to move his right upper extremity and right lower extremity. During a review of Resident 49's AR, dated 8/7/25, the AR indicated Resident 49 was admitted to the facility on [DATE] with diagnosis of Hemiplegia (paralysis on one side of the body)and hemiparesis (muscle weakness on side of the body) following Cerebral Infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, Aphasia following Cerebral Infarction, Dysphagia (difficulty swallowing) following Cerebral Infarction, and Dysarthria (difficulty speaking due to weak speech muscles) following Unspecified Cerebrovascular Disease (loss of blood flow to a part of the brain). During a review of Resident 49's MDS, dated [DATE], the MDS section C indicated Resident 49's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 49's BIMS Summary Score was blank. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/6/2025 at 12:16 p.m. with CNA 5, in Resident 49's room, CNA 5 stated she communicated with Resident 49 by pointing out the items and using gestures. CNA 5 stated she was not aware of a communication book or communication board (a visual aid that uses pictures, symbols, or text to help people with communication difficulties express their needs, wants, and ideas). CNA 5 stated she never saw a communication board at Resident 49's bedside. CNA 5 stated Resident 49 used a different language and was difficult to understand. CNA 5 stated she was not sure what language it was. During a concurrent observation on 8/6/2025 at 12:20 p.m. with CNA 7, in Resident 49's room, CNA 7 was serving the lunch tray at the bedside table in front of Resident 49. CNA 7 stated she did not see a communication board at bedside. CNA 7 stated Resident 49 should have a communication board at bedside to be able to communicate with him. During a concurrent observation and interview on 8/6/2025 at 4:30 p.m. with Licensed Vocational Nurse (LVN) 2, in Resident 49's room, LVN 2 was looking for the communication book at Resident 49's bedside. LVN 2 opened the first drawer of Resident 49's bedside dresser, the communication board was located underneath the fruits and stated, .looks like it has never been used. LVN 2 stated the communication board was dirty and sticky with bread crumbs and sticky paste all over the communication board. LVN 2 stated there was no communication book at bedside and stated, not that I know of. LVN 2 was holding the communication board and stated, this is not a communication book. LVN 2 stated she needs to clean the communication board and should be placed within easy access. Resident 49 was continuously making sound with words of dadadada. Resident 49 looks frustrated, and his face turned red. LVN 2 stated she was unable to tell what the language the resident was speaking and stated, I will find out. LVN 2 called the family and brought the phone to Resident 49 to interpret what Resident 49 was trying to say. LVN 2 stated the family translated in English and per family it was random words. During a concurrent interview and record review on 8/08/2025 at 11:50 a.m. with LVN 3, Resident 49's EMR titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, .The resident has a communication problem/t Expressive Aphasia, stroke primary language is Persian. Date initiated 4/17/24, interventions: Monitor effectiveness of communication strategies and assistive device (Communication Book) . Date initiated 4/17/24, . Monitor effectiveness of communication strategies and assistive device (Communication Poster) . Revision on:8/7/25. LVN 3 stated she was not aware of the communication book or the communication poster. LVN 3 stated she hadn't seen a communication book nor the communication poster at Resident 49's bedside. LVN 3 stated she never used a communication poster when communicating with Resident 49. LVN 3 stated staff communicate with Resident 49 by pointing on objects and use of facial expression. LVN 3 stated Resident 49 can respond to yes and no questions by nodding and left-hand movements. LVN 3 stated Resident 49 had slurred speech and mumbled. LVN 3 stated Resident 49 can understand basic English, and his primary language was Persian Language. LVN 3 stated Resident 49 should utilize a translator service for Persian language. LVN 3 stated the care plan should be specific to the needs of the residents. LVN 3 stated care plan should be implemented and followed to communicate effectively with Resident 49. During an interview on 8/13/2025 at 4:20 p.m. with the DON, the DON stated Resident 49's care plan intervention for the communication book should be implemented and followed by staff to properly and effectively communicate with the resident. The DON stated all residents who speaks non-English language and had difficulty speaking should have a communication board at bedside to express their needs. The DON stated resident's care plan should be person-centered. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/14/2025 at 2:15 p.m. with the Social Services Director (SSD), the SSD stated she had not encountered a Persian speaking language resident. The SSD stated the facility do not a have a staff who can understand and speak a Persian language. The SSD stated she will find a translator or interpreter services for residents that cannot speak and understand English. The SSD stated Resident 49 was provided with a communication poster. The SSD stated the facility does not have a communication book. During a review of the facilities P&P titled, Care Plans, Comprehensive Person Centered, revised March 2023, the P&P indicated, . 3. The care plan intervention is derived from analysis of the information gathered as part of the comprehensive assessment.7. the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; c. includes the resident's stated goals upon admission and desired outcomes.reflects currently recognized standards of practice for problem areas and conditions. 3. During a review of Resident 68's AR, dated 6/25/25, the AR indicated, Resident 68 was admitted to the facility on [DATE] with the following diagnoses: unspecified sequel of cerebral infarction (the long-term effects or consequences of a stroke), muscle weakness (a reduced ability of one or more muscles to generate force), contracture of the left shoulder (a condition characterized by pain and stiffness in the shoulder), and dysphagia (medical condition characterized by difficulty swallowing). During a review of Resident 68's, Meal Ticket (document which outlines resident meal preferences, ordered diet, and allergies, undated, the Meal Ticket, indicated, .mechanical soft texture . Assist Instructions: scoop plate . During a review of Resident 68's, Order Summary Report, dated 8/13/25, the Order Summary Report indicated, . Order Summary . Fortified/high protein diet Mechanical soft texture . use of scoop plate for all meals . During an observation on 8/5/25 at 12:05 p.m. in the assisted feeding dining room, Resident 68's meal tray had a regular plate instead of a scoop plate and he was served a hard piece of toast. During a concurrent observation and interview on 8/5/25 at 12:16 p.m. with CNA 6, CNA 6 stated Resident 68 was not provided with a scoop plate. CNA 6 stated Resident 68 needed to have a scoop plate because he had muscle weakness, and a scoop plate allowed him to eat his meals better. During a concurrent observation and interview on 8/5/25 at 12:16 p.m. with CNA 6, CNA 6 stated Resident 68 received burnt toast as part of his meal. CNA 6 stated Resident 68 should not have been given the piece of hard toast because he was on a mechanical soft diet, and he may have trouble eating it which could cause him to choke. During concurrent observation and interview on 8/5/25 at 12:16 p.m. with the Speech Language Pathologist (SLP), Resident 68 received hard toast for lunch. The SLP stated Resident 68 was on a prescribed mechanical soft diet and the piece of hard toast on his plate should not have been provided. The SLP stated Resident 68 needed to receive softer slices of bread to be able to eat it comfortably, he had not progressed enough to be able to adequately eat and swallow the toast. During an interview on 8/12/25 at 4:27 p.m. with the Infection Preventionist (IP), the IP stated she was checking meal trays before they were sent to the residents on Monday 8/5/25. The IP stated she checks the meal trays and compares them with the Meal Ticket in order to ensure the residents (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receive the correct meal in regards to meal preferences, special equipment, ordered diet, and food allergies. The IP stated she did not notice if the toast provided to Resident 68 was too hard, the kitchen staff should have noticed as well when they placed the food on the plates. The IP stated providing Resident 68 with a scoop plate helped the resident be able to better feed himself and help promote independence since he did suffer from deficits related to a past stroke. The IP stated providing Resident 68 with the correct meal consistency would ensure he did not aspirate (inhaling a substance other than air into the lungs) or choke on his food if he tried to eat something he could not handle. During an interview with CNA 5, CNA 5 stated scoop plates were provided to residents with weaknesses in order to provide more independence to the residents. These residents have weaknesses that make eating their meals difficult, providing a scoop plate helps residents feel more dignified if they can help feed themselves. CNA 5 stated a mechanical soft diet is determined by the SLP, it is an evaluation to see what a resident can and ca not swallow, if a resident gets an inappropriate diet they may have a hard time swallowing their food which would then put the resident at risk for choking. CNA 5 stated residents should never get the wrong diet. During a concurrent interview and record review on 8/13/25 at 9:35 a.m. with the Certified Dietary Manager (CDM), Resident 68's Meal Ticket, undated, was reviewed. The Meal Ticket, indicated Resident 68 was on a mechanical soft diet and was to be provided a scoop plate. The CDM stated a person on a mechanical soft diet should not have received hard toast during their lunch, kitchen staff should have caught it during the tray line (food assembly system in a facility where food trays are prepared). The CDM stated Resident 68 had dysphagia and may have trouble eating the food if it was not the right consistency. The CDM stated Resident 68 was also supposed to have a scoop plate because it would help him be able to scoop the food on his own, it also could have helped him feel more independent if he was able to do it on his own. During a concurrent interview and record review on 8/13/25 at 10:26 a.m. with LVN 4, Resident 68's Clinical Record (CR), dated 8/13/25, was reviewed. The CR indicated Resident 68 had a diagnosis of dysphagia and cerebral infarction and Resident 68 was prescribed a mechanical soft diet with instructions to use a scoop plate for all meals. LVN 4 stated Resident 68 should not have received hard toast since he had dysphagia which made it difficult to swallow food. LVN 4 reviewed Resident 68's Comprehensive Care Plan, dated 8/13/25, the Comprehensive Care Plan indicated Resident 68 was at risk for altered nutrition due to his dysphagia and he was to be provided with his ordered diet and a scoop plate for all meals. LVN 4 stated the care plan was not followed and Resident 68 could have choked as a result. During an interview on 8/13/25 at 10:48 a.m. with the Director of Staff Development (DSD), the DSD stated staff needed to ensure meal trays were accurate before a resident ate their food because inaccurate diets may lead to a resident choking on their food During an interview on 8/14/25 at 1:53p.m. with the Assistant Director of Nursing (ADON) Resident 68's Comprehensive Care Plan, dated 8/14/25, was reviewed. The Comprehensive Care Plan indicated Resident 68 was to be given a mechanical soft diet with a scoop plate. The ADON stated Resident 68's care plan indicated to provide his diet as ordered throughout various sections of the plan. The ADON stated Resident68's Comprehensive Care Plan interventions were not followed. The ADON stated the Comprehensive Care Plans purpose was too easily inform staff of the care and interventions a resident required. Nurses and CNAs can both see what interventions to follow and (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	what was supposed to be implemented for all the residents. The ADON stated providing Resident 68's prescribed diet was important because otherwise he could aspirate and experience weight loss if he did not eat. The ADON stated the scoop plate helps encourage him to eat and it also helps promote independence which may raise his self-esteem. During a review of the facility's policy and procedure (P&P) titled, Meals, dated 3/23, the P&P indicated, .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . 4. Residents who may Benefit from Assistive Devices: 1. Adaptive devices (Special eating equipment and utensils) will be provided for residents who need or request them .2. Assistance will be provided to ensure than residents can use and benefit from special eating equipment and utensils . During a review of the facility's P&P titled, Food and Nutrition Services, dated 10/17, the P&P indicated, .6. Nursing staff will ensure that assistive devices are available to residents as needed. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, dated 3/23, the P&P indicated, .7. The comprehensive, person centered care plan: a. includes measurable objectives and timeframes b. describes the services that are to be furnished to attain or maintain highest practicable physical, mental, and psychosocial well-being. 4. During a review of Resident 185's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/13/25, the AR indicated Resident 185 had a history of left femur fracture (Thigh bone had been broken. This bone goes from the hip down to the knee), osteoporosis (a disease that made a person's bones weak, thin and break more easily), and abnormalities of gait and mobility (the way a person walked or moved was not normal. This could include walking with a limp, dragging a foot, moving slowly, or having trouble keeping balance). During a review of Resident 185's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 185 had no cognitive impairment. During an observation on 8/6/25 at 8:21 a.m. in Resident 185's room, Resident 185's bed was observed not to be in the lowest position. The bed height was approximately two feet from the floor and matched the height of the roommate's bed, who was not identified as a fall risk. Resident 185 was lying in bed at the time of the observation. During a concurrent observation and interview on 8/6/25 at 2:24 p.m. with Certified Nursing Assistant (CNA) 3, Resident 185's bed was observed to not be in the lowest position. CNA 3 stated Resident 185's bed could go lower and confirmed that it was not currently in the lowest position. CNA 3 then lowered Resident 185's bed approximately one foot. During an interview on 8/12/25 at 2:08 p.m. with CNA 4, CNA 4 stated fall precautions included ensuring the residents had their call light, the bed was in the lowest position, and personal items were within reach. CNA 4 stated the care plan contained all necessary information about the residents and (continued on next page)		

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

Printed: 07/30/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provided daily guidance regarding their care. CNA 4 stated if the care plan specified the bed was to be in the lowest position, it should consistently be maintained that way. During an interview on 8/12/25 at 2:30p.m. with Registered Nurse (RN) 1, RN 1 stated care plans were important as they provided the care plan to be followed. RN 1 stated care plans were based on the residents' condition and guided staff in providing appropriate care. RN 1 stated care plans informed staff on how to assist the residents and that care planned interventions should be carried out. RN 1 identified common fall risk interventions, including keeping the bed in the lowest position, ensuring items were within reach, providing reminders to use call light, performing frequent checks and keeping breaks locked. During an interview on 8/14/25 at 10:59a.m. with the Director of Nursing (DON), the DON stated it was expected that the bed be placed in the lowest position if specified in the care plan, as this intervention was intended to help prevent resident falls. It was further expected that all care planned interventions be consistently carried out. During a review of Resident 185's MDS Section GG-Functional Abilities-admission (MDS- GG), dated 7/15/25, the MDS- GG indicated Resident 185 required assistance with eating, substantial assistance with oral hygiene, was dependent in toileting, required substantial assistance with upper body dressing, was dependent in lower body dressing, and was dependent in putting on and removing footwear. During a review of Resident 185's Fall Risk Assessment, dated 7/30/25, the Fall Risk Assessment indicated Resident 185 had experienced a fall within the past 6 months and was determined to be a risk for falls. During a review of Resident 185's Care Plan Report, dated 7/14/25, the Care Plan Report indicated Resident 185 was a risk for falls related to limited mobility, muscle weakness and abnormalities of gait and mobility. The goal of the care plan was for Resident 185 to remain free from minor injury. A listed intervention included keeping Resident 185's bed in the lowest position. During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person Centered, revised March 2023, the P&P indicated, 3. The care plan intervention is derived from analysis of the information gathered as part of the comprehensive assessment. 7. the comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; c. includes the resident's stated goals upon admission and desired outcomes. reflects currently recognized standards of practice for problem areas and conditions.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to ensure all prescribed medications were available and administered to residents as scheduled for three of seven sampled residents (Resident 53, 82 and 144) when the facility did not have the medications available for administration. This failure placed Residents 53, 82 and 144 at risk for not receiving the physician ordered medical treatment, placing residents at risk for ineffective management of their medical conditions. Findings: 1. During an observation of the medication administration task on 8/6/25 at 8:50 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she did not administer Resident 53's [Polyethylene glycol] (medication that helps people have bowel movements), because it was not available in her medication cart. During a review of Resident 53's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/7/25, the AR indicated Resident 53 has a history of constipation (when a person had a hard time going to the bathroom because their stools were too hard, dry or did not come out easily). During a review of Resident 53's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 5/16/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 53 had no cognitive impairment. During a review of Resident 53's Medication Administration Record (MAR), dated month of August 2025, the MAR indicated Resident 53's [Polyethylene glycol] was not administered on 8/6/25 at 8:00 a.m. 2. During an observation of the medication administration task on 8/6/25 at 9:00 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she did not administer Resident 82's 10 mg (milligram-a small unit to measure weight) Oxybutynin (medication that helped relax the bladder [a hollow organ that held pee until a person was ready to use the restroom] tablet and Vitamin E, because it was not available in the medication cart. During a review of Resident 82's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/7/25, the AR indicated Resident 82 had a history of overactive bladder (a condition where a person's bladder muscles worked too often). During a review of Resident 82's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 7/7/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 3 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 82 had severe cognitive impairment. During a review of Resident 82's Medication Administration Record (MAR), dated month of August 2025, the MAR indicated Resident 82's Oxybutynin 10 mg tablet and Vitamin E 200 mg tablet was not administered on 8/6/25 at 9:00 a.m. 3. During an observation of the medication administration task on 8/6/25 at 9:12 a.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated she did not administer Resident 144's isosorbide mononitrate extended release (medication that helps relax and widen blood vessels so the heart can get more blood and oxygen) 24 Hour 60 mg tablet because it was not available in her medication cart. Resident's blood pressure obtained prior to medication administration was 122/68. During a review of Resident 144's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/7/25, the AR indicated Resident 144 had a history of heart failure (a condition in which the heart was not able to pump blood as well as it should), and hypertension (when blood pushes too hard against the walls of the blood vessels). During a review of Resident 144's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 6/24/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 11 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 144 had moderate cognitive impairment. During a review of (continued on next page)		

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

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Form Approved OMB
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 144's Medication Administration Record (MAR), dated month of August 2025, the MAR indicated Resident 144's Isosorbide Mononitrate extended release 24-hour 60 mg tablet was not administered. During an interview on 8/14/25 at 10:13 a.m. with LVN 4, LVN 4 stated all nurses were responsible for checking that resident's medications were available. During an interview on 8/14/25 at 10:20 a.m. with LVN 6, LVN 6 stated nurses were to check the residents' supply of medications, and if it appeared the supply was getting low, they were to reorder the medication or notify the charge nurse. During an interview on 8/14/25 at 10:59 a.m. with the Director of Nursing (DON), the [NAME] stated it was the responsibility of the nurse to reorder medications that were running low. The DON stated nurses needed to ensure residents did not run out of their regularly scheduled medications, as this placed the residents at risk. During a review of facilities Charge Nurse Job Description, date unknown, the Charge Nurse Job Description indicated, order prescribed medications, supplies, and equipment as necessary, and in accordance with established policies. ensure that an adequate stock level of medications, medical supplies, equipment etc., is maintained on your unit/shift at all times to meet the needs of the residents. During a review of the facilities policy and procedure (P&P) titled, Pharmacy Services Overview, revised April 2024, the P&P indicated, residents have sufficient supply of their prescribed medications and receive medications (routine, emergency or as needed) in a timely manner. nursing staff communicate prescriber orders to the pharmacy and are responsible for contacting the pharmacy if a resident's medication is not available for administration.		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide assistive devices during meals for three of 12 residents (Resident 44, 68, and 67) when: 1. Resident 44 was not provided with a right-hand built-up spoon (an adaptive dining aid [a device used to assist with feeding] designed for people who have limited grasp or face difficulties in supination) during his lunch on 8/5/25. This failure resulted in for Resident 44 not being able to feed himself and had the potential risk of losing his independence when eating. 2. Resident 68 was not provided a scoop plate (an assistive plate which helps people scoop up food onto a utensil) during his lunch on 8/5/25 This failure had had the potential to result in Resident 68 to not be able to eat his meal 3. Resident 67's food was not served in bowls on her meal tray during lunch on 8/5/25. This failure had the potential to limit Resident 67's ability to feed herself independently and safely. 1. During a concurrent observation and interview on 8/5/25 at 12:20 p.m. with Resident 44, in the dining room, Resident 44 was sitting up in a wheelchair eating lunch meal with the assistance of Speech Language Pathologist (SLP). Resident 44 had a scoop plate. Resident 44 smiled when asked how are you? During a concurrent interview and record review on 8/5/25 at 12:23 p.m. with the Speech Language Pathologist (SLP), in the dining room, Resident 44's Meal Ticket (document which outlines resident meal preferences, ordered diet, and allergies), undated was reviewed. The Meal Ticket indicated, .Puree/Level 4 Texture. Assist instruction: scoop plate, RIGHT-HANDED BUILT-UP SPOON. The SLP stated Resident 44's right-handed built-up spoon was not provided by the kitchen in Resident 44's tray. The SLP stated Resident 44 should have a right-handed built-up spoon in his meal tray and stated, the kitchen forgot to put it in the tray. The SLP stated Resident 44's right-handed built-up spoon helped him with self-feeding. During a review of Resident 44's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/14/25, the AR indicated, Resident 44 was admitted to the facility on [DATE]with the following diagnoses: Fracture of Ramus of Right Mandible (a rare break of the vertical part of the lower jaw on the right side), Dysphagia (medical condition characterized by difficulty swallowing)., Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and Essential Hypertension (HTN-high blood pressure). During a review of Resident 44's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/22/25, the MDS section C indicated Resident 44 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was severely impaired. During a review of Resident 44's, Order Summary Report, dated 8/14/25, the Order Summary Report indicated, . Order Summary . built up straight spoon . During an interview on 8/8/25 at 11:16 a.m. with the Director of Rehabilitation (DOR), the DOR stated residents that requires adaptive equipment (devices designed to assist people with physical limitations to be able to feed themselves) like scoop plates, built-up utensils should be provided when eating to be able to feed themselves and to prevent food and drink spillage. (continued on next page)		

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/25 at 2:15 p. with the Director of Nursing (DON), the DON stated using adaptive equipment like scoop plates and built-up utensils is important to help residents when eating and increase their independence during meals. The DON stated residents' adaptive equipment should be provided in their meal tray and should be available for every meal. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, dated 7/17, the P&P indicated, . Residents shall receive assistance with meals in a manner that meets the individual needs of each resident .Residents who may Benefit from Assistive Devices: 1. Adaptive devices (Special eating equipment and utensils) will be provided for residents who need or request them .2. Assistance will be provided to ensure than residents can use and benefit from special eating equipment and utensils . 2. During a review of Resident 68's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/25/25, the AR indicated, Resident 68 was admitted to the facility on [DATE] with the following diagnoses: unspecified sequel of cerebral infarction (the long-term effects or consequences of a stroke), muscle weakness (a reduced ability of one or more muscles to generate force), contracture of the left shoulder (a condition characterized by pain and stiffness in the shoulder), and dysphagia. During a review of Resident 68's, Meal Ticket, undated, the Meal Ticket, indicated, .mechanical soft texture . Assist Instructions: scoop plate . During a review of Resident 68's, Order Summary Report, dated 8/13/25, the Order Summary Report indicated, . Order Summary . use of scoop plate for all meals . During an observation on 8/5/25 at 12:05 p.m. in the assisted feeding dining room, Resident 68's meal tray had a regular plate instead of a scoop plate. During a concurrent observation and interview on 8/5/25 at 12:16 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 68 was not provided with a scoop plate. CNA 6 stated Resident 68 needed to have a scoop plate because he has muscle weakness, and a scoop plate allowed him to eat his meals better. During an interview on 8/12/25 at 4:27 p.m. with the Infection Preventionist (IP), the IP stated she was checking meal trays before they were sent to the residents on Monday 8/5/25. The IP stated she checks the meal trays and compares them with the Meal Ticket in order to ensure the residents receive the correct meal in regard to meal preferences, special equipment, ordered diet, and food allergies. The IP stated she did not notice Resident 68 was not provided a scoop plate. The Ip stated providing Resident 68 with a scoop plate helped the resident be able to better feed himself and help promote independence since he did suffer from deficits related to a past stroke. During an interview with CNA 5, CNA 5 stated scoop plates were provided to residents with weaknesses in order to provide more independence to the residents. These residents have weaknesses that make eating their meals difficult, providing a scoop plate helps residents feel more dignified if they can help feed themselves. During a concurrent interview and record review on 8/13/25 at 9:35 a.m. with the Certified Dietary Manager (CDM), Resident 68's Meal Ticket, undated, was reviewed. The Meal Ticket, indicated Resident 68 was to be provided a scoop plate. The CDM stated Resident 68 was supposed to have a (continued on next page)		

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

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scoop plate because it would help him be able to scoop the food on his own, it also could have helped him feel more independent if he was able to do it on his own. During an interview on 8/13/25 at 11:07 a.m. with the DON, the DON stated Resident 68 should have been provided with his scoop plate during lunch. The DON stated a scoop plate would have helped Resident 68 scoop the food onto his spoon and actually attempt to eat it on his own. During a review of the facility's P&P titled, Food and Nutrition Services, dated 10/17, the P&P indicated, .6. Nursing staff will ensure that assistive devices are available to residents as needed. 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . During a review of the facility's P&P titled, Meals, dated 3/23, the P&P indicted, .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . 4. Residents who may Benefit from Assistive Devices: 1. Adaptive devices (Special eating equipment and utensils) will be provided for residents who need or request them .2. Assistance will be provided to ensure than residents can use and benefit from special eating equipment and utensils . 3. During an observation on 8/5/25 at 12:14 p.m. in the dining room, Resident 67's meal tray had her food served on a plate. During a review of Resident 67's meal ticket, the meal ticket indicated, Assist Instructions: Food in Bowls During a review of Resident 67's admission Record, dated 8/8/25, the admission Record indicated Resident 67 was admitted to the facility on [DATE] with diagnoses which included Generalized Osteoarthritis (joint disease that causes the breakdown of cartilage, the smooth tissues that cushions and protects joints.), glaucoma (group of eye diseases that damage the optic nerve which sends visual information to the brain) and hearing loss. During a review of Resident 67's Order Summary Report (OSR) dated 8/8/25, the OSR indicated, . Regular diet Regular texture, Thin consistency, food in bowls. During a concurrent observation and interview on 8/5/25 at 12:20 p.m. with Certified Nursing Assistant (CNA) 10, CNA 10 stated Resident 67's food is placed on regular plate, the ticket was to put food in bowls. CNA 10 stated Resident 67's food should have been in bowls for Resident 67 to pick up her food easier and feed self safely. CNA 10 stated the licensed nurse inspecting the food trays should have been checking the trays for the proper equipment and could have been corrected before the food was served to Resident 67. During an interview on 8/8/25 at 9:24 a.m. with Dietary [NAME] (DC) 1, she stated the instructions on the meal ticket should be followed. DC 1 stated the order for food to be placed in bowls should be followed on all meals, we have bowls in the kitchen to use and there was reasons why residents had orders for special equipments. DC 1 stated the last person in the tray line should have checked the tray making sure everything was followed including food in bowls. During an interview on 8/8/25 at 10:25 a.m. with the Certified Dietary Manager/Driver (CDM/D), he stated the responsibility should have started in the kitchen. The CDM/D stated it was the responsibility of the dietary staff during the tray line to ensure orders were followed and once the (continued on next page)		

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

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	food tray leaves the kitchen, it then becomes the responsibility of the nursing staff. The CDM/D stated it was important to follow the instructions in the meal ticket to ensure residents' safety during meals. During a phone interview on 8/12/25 at 4:10 p.m. with Registered Dietitian (RD), the RD stated the expectation was for dietary staff to follow order on how food should be served. The RD stated the order for food to be placed in bowls should have been followed, it was more convenient for residents to eat. During a review of facility's policy and procedure (P&P) titled, Assistance with Meals, dated 7/17, the P&P indicated, . 1. Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged /padded handles, plate guards, and/or specialized cups.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a completed physician informed consent (the process in which residents are given important information of the possible risk and benefits of psychoactive medications) for the use of psychotropic medication (medication used to treat mental and behavioral disorders) was obtained for two of nine sampled residents (Resident 95 and Resident 108) when: Resident 95 had an active order for sertraline (psychotropic medication used to treat conditions such as depression) oral tablet, ordered on 7/5/25, with no electronic provider signature prior to administration. Resident 108 had an active order for aripiprazole (psychotropic medication used to treat conditions such as schizophrenia), ordered on 3/19/25, with no name of the licensed nursing staff that prepared and verified the consent form. These failures resulted in the violation of Resident 95's and Resident 108's right to be informed of, in advance, of their anti-psychotic medication treatment risks and benefits by a physician or alternative treatment options which could lead to negative side effects. 1. During a review of Resident 95'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 8/12/25, the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (condition in which brain tissue dies due to lack of blood flow), epilepsy (seizures due to abnormal brain activity), stiff-man syndrome (disorder which includes fluctuating muscle rigidity and spasms triggered by noise, touch, or distress), major depressive disorder (persistent sadness), and anxiety disorder (persistent worry and fear). During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/22/25, the MDS indicated Resident 95 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 95 was cognitively intact. During a review of Resident 95's Order Summary Report (OSR), dated 8/12/25, the OSR indicated Resident 95 had an order for, .sertraline HCl oral tablet 50 MG [milligrams- unit of measurement for medication dosage].give 0.5 tablet by mouth one time a day for major depressive disorder.active.order date 7/5/25.start date 7/6/25. During a review of Resident 95's Informed Consent-Psychoactive Medication- V 2 (ICPM), dated 7/5/25, the ICPM did not indicate the provider electronically signed the consent. During a review of Resident 95's Medication Administration Record (MAR), dated 8/12/25 and 8/13/25, the MAR indicated, .sertraline HCl oral tablet 50 MG.give 0.5 tablet by mouth one time a day for major depressive disorder. had been administered daily, per the order, since 7/5/25. 2. During a review of Resident 108's AR, dated 8/12/25, the AR indicated Resident 108 was admitted to the facility on [DATE] with diagnoses of heart failure (heart does not pump blood properly), atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), repeated falls, and schizophrenia (mental illness which affects ability to think, feel and behave clearly). During a review of Resident 108's MDS, dated 6/13/25, the MDS indicated Resident 108 had a BIMS score of 15, which suggested Resident 108 was cognitively intact. During a review of Resident 108's OSR, dated 8/12/25, the OSR indicated Resident 108 had an order for, .aripiprazole oral tablet 15 MG.give 1 tablet by mouth one time a day for schizophrenia.active.order date 3/19/25.start date 3/20/25. During a review of Resident 108's Informed Consent-Psychoactive Medication- V 2 (ICPM), dated 3/19/25, the ICPM did not indicate the name of the licensed nurse that verified informed consent and prepared the consent. During a concurrent interview and record review on 8/8/25 at 11:19 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 95's and Resident 108's ICPM's, dated 7/5/25 and 3/19/25 were reviewed. LVN 3 stated all consents were completed and obtained electronically. LVN 3 stated the (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provider was responsible for contacting the resident or resident responsible party (RP) and obtain informed consent. LVN 3 stated licensed nursing staff was responsible for ensuring informed consent was obtained by the provider and completing ICPM documentation. LVN 3 stated medical records staff was responsible to follow up on ICPM's and ensure they were signed electronically. LVN 3 stated Resident 95's sertraline ICPM did not contain an electronic provider signature, and the medication had been administered. LVN 3 stated Resident 108's aripiprazole ICPM did not contain the name of the licensed nurse that prepared the ICPM form and ensured informed consent had been obtained by the provider. LVN 3 stated progress notes or alternative documentation did not replace informed consent. LVN 3 stated it was important to ensure ICPM's were completed accurately and completely to ensure residents and/or RP's were informed of their proposed treatment, risk, benefits and alternatives to treatment. During a concurrent interview and record review on 8/8/25 at 11:38 a.m. with the Medical Records Assistant (MRA), Resident 95's and Resident 108's ICPM's, dated 7/5/25 and 3/19/25 were reviewed. The MRA stated medical record staff reviewed electronic consents by performing audits and ensuring providers electronically signed ICPM's. The MRA stated they reviewed ICPM's to ensure they were filled out completely with the licensed nurses name, resident name, date, time, medication information and electronic provider signature. The MRA stated Resident 95's sertraline ICPM did not contain an electronic provider signature and was therefore incomplete. The MRA stated Resident 108's aripiprazole ICPM did not contain the licensed nurses name that prepared the form or verified informed consent and therefore was incomplete. The MRA stated it was facility policy to ensure all information was documented on the informed consent form prior to medication administration. During an interview on 8/12/25 at 3:45 p.m. with the Pharmacist Consultant (PC), the PC stated informed consent was expected to be obtained prior to medication administration. The PC stated to ensure residents and/or resident RP's were informed of purposed treatment in advance all aspects of the form needed to be filled out and completed, which included resident name, date, time, licensed nursing staff whom prepared the form and provider signature. During an interview on 8/14/25 at 1:49 p.m. with the Director of Nursing (DON), the DON stated sertraline and aripiprazole were psychotropic medications which required informed consent prior to administration. The DON stated informed consents were legal documents and could not be replaced by a progress note. The DON stated all aspects of the informed consent needed to be completed for the document to be valid which included, resident name, medication information, name of licensed nursing staff preparing the form and validating informed consent was obtained by the provider, and a provider signature. The DON stated the provider was responsible to obtain informed consent and electronically sign the informed consent. The DON stated licensed nursing staff were responsible to ensure informed consents forms were completed. The DON stated medical record staff reviewed informed consents by completing audits to ensure ICPM's were completed in entirety. The DON stated Resident 95's sertraline ICPM did not contain an electronic provider signature. The DON stated Resident 108's aripiprazole ICPM did not contain the name of the licensed nurse that prepared the form or verified informed consent was obtained. The DON stated facility policy had not be followed when Resident 95's and Resident 108's ICPM's were not complete. The DON stated it was important to ensure informed consents were complete and accurate to ensure residents and/or resident RP's were informed in advance of the psychotropic medications they were taking, including risks, benefits and alternative treatment options. The DON stated Resident 95 and Resident 108 were at risk of not knowing their rights to the psychotropic medications they were administered. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2/2023, the P&P indicated, .be notified of his or her medical condition and of any changes in his or her condition.be informed of, and participate in, his or her care planning and treatment. During a review of the facility's P&P titled, Health, Medical Condition and Treatment Options, Informing Residents of, dated 2/2021, the P&P indicated, .each resident is informed of his/her total health status and medical condition, including diagnosis, treatment recommendations and prognosis, in advance of treatment and on an on-going basis. If a resident has (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an appointed representative, the representative is also informed.the resident's attending physician, the facility's medical director, or the director of nursing services is responsible for informing the resident of his or her medical condition. Such information includes providing the resident/representative with information about the resident's.psychosocial status.type of care or treatment recommended based on the assessment and care plan).risks and benefits of proposed care or treatment.During a review of the facility's P&P titled, Psychotropic Medication Use/Informed Consent, dated 3/2024, the P&P indicated, .residents, families, and/or the representative are involved in the medication management process.the actual or intended benefit of the medication is understood by the resident/representative. resident's (and/or representatives) have the right to decline treatment with psychotropic medications.the staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.the signed written consent must be recorded in the resident's medical record. Before initiating treatment with psychotherapeutic drugs, facility staff must verify that the resident's health record contains written informed consent with the required signatures.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment (MDS -assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of six sampled residents (Resident 13) when Resident 13's antidepressant medication (used to treat depression and mental health conditions), and anticoagulant medication (used to prevent blood clots from forming) use were inaccurately coded on the MDS assessment. These failures had the potential to result in Resident 13's care needs not met. During a review of Resident 13's admission Record, dated 8/8/25, the admission record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one sided weakness or partial paralysis), depression (feeling of persistently sad and hopeless, impacting ability to enjoy life and carry out daily activities), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing and unspecified atrial fibrillation (heart upper chambers beat irregularly and often rapidly). During a review of Resident 13's Order Summary Report, dated 8/8/25, the Order Summary Report, indicated, .Apixaban Oral Tablet 5 MG [milligram-unit of measurement], Give 5 mg by mouth two times a day.Start Date: 4/18/25. Sertraline HCL [hydrochloride] Oral Tablet 25 MG (Sertraline HCl) Give 25 mg by mouth one time a day. Start Date: 4/22/25. [brand name] Oral tablet 10 MG (empagliflozin) Give 1 [one] tablet by mouth one time a day. During a concurrent interview and record review on 8/13/25 at 11:22 a.m. with Minimum Data Set Nurse (MDS) 1 and MDSN 2, Resident 13's MDS assessment Section N (medications) dated 7/15/25 was reviewed. MDSN 1 and MDSN 2 stated Resident 13 received antidepressant medication and anticoagulant medication. MDSN 1 and MDSN 2 stated Resident 13's use of antidepressant medication and anticoagulant medication were not coded in the MDS assessment dated [DATE]. MDSN 1 and MDSN 2 stated Resident 13 should have been coded as receiving antidepressant medication and anticoagulant medications. During an interview on 8/14/25 at 10:15 a.m. with the Director of Nursing (DON), the DON stated her expectation when it comes to the MDS assessment was for everyone completing the assessment to be accurate and completed on time. The DON stated both MDSN 1 and MDCN 2 are new and are LVNs and she submits or transmits the assessments, but she was not responsible in checking for accurateness. During a review of facility's policy and procedure (P&P) titled, Resident Assessments, dated 10/23, the P&P indicated, .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments. Assessments are completed by staff members who have the skills and qualifications to assess relevant care areas. All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of the information.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nail care was provided for one of nine sampled residents (Resident 49) when Resident 49's fingernails were long, jagged (sharp, uneven edges) and dirty with brownish to blackish dirt built up underneath the nails. This failure had potential for Resident 49 in obtaining avoidable skin related injuries and infection (the invasion and growth of germs in the body). During a concurrent observation and interview on 8/5/25 at 11:02 a.m. with Resident 49, in Resident 49's room, Resident 49 was lying in bed. Resident 49 was awake with slurred (indistinct and difficult to hear or understand) speech and was able to respond during conversation by nodding his head using yes and no questions. Resident 49 was unable to move his right upper extremity and right lower extremity. Resident 49 moved his left hand towards the left side of the bed. Resident 49's right hand was elevated with pillow; right hand was closed in a fist (a hand with a finger s clenched in the palm) position with minimal swelling. Resident 49 was unable to open his right hand. Resident 49 had no washcloth or palm protector on right hand. During a review of Resident 49's MDS, dated [DATE], the MDS section C indicated Resident 49's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 49's BIMS Summary Score was blank. During a review Resident 49's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/14/25, the AR indicated Resident 49 was admitted to the facility on [DATE] with diagnosis of Hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on side of the body) following Cerebral Infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, Aphasia following Cerebral Infarction, Dysphagia (difficulty swallowing) following Cerebral Infarction, Dysarthria (difficulty speaking due to weak speech muscles) following Unspecified Cerebrovascular Disease (loss of blood flow to a part of the brain), Contracture (is tightening and shortening of the surrounding soft tissues which then restrict joint [a connection of two bones in the skeletal system] movement). of Muscle Right Hand, and Contracture, Unspecified Joint. During a concurrent observation and interview on 8/6/25 at 12:16 p.m. with Certified Nursing Assistant (CNA) 11, in Resident 49's room, CNA 11 checked Resident 49's right and left hand. CNA 2 stated Resident 49's right hand was contracted and stated, .like a fist. CNA 11 attempted to open Resident 49's right hand and stated CNA fingernails are long with brownish to blackish dirt built-up underneath the nails. CNA 11 stated there was no washcloth or palm protector applied to Resident 49's right hand. CNA 11 stated Resident 49 had not been wearing a splint (is a device designed to prevent contractures by gently stretching and maintaining the position of affected joints, such as the hand, wrist, or foot) to the right hand. CNA 11 Resident 49's left hand fingers were long, jagged and dirty with brownish to blackish dirt underneath the nails and the left thumb finger with brownish stained. CNA 11 stated Resident 49's fingernails should be trimmed and cleaned because Resident 49 uses his left hand when eating. CNA 11 stated she will provide nail care to Resident 49 and will clean his hands. CNA 11 stated CNAs were responsible in doing nail clipping and nail care. During an interview on 8/12/25 at 2:32 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Licensed Nurses conduct weekly checks of resident's fingernails every Sunday to ensure fingernails are trimmed and cleaned to prevent infection and self-inflicting scratches and injury. The ADON stated Resident 49 had a right-hand contracture, a washcloth should be applied and kept his fingernails trimmed to prevent self-inflicting scratch and injury to the palm of the hand. During a concurrent observation and interview on 8/8/25 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 49's room, LVN 3 checked Resident 49's right and left hand. LVN 3 stated Resident 49's right left fingernails were long and dirty with brownish to blackish built-up dirt underneath the nails. LVN 3 stated CNAs do nail clipping every Sunday. LVN 3 stated Resident 49's fingernails should be cleaned and trimmed to prevent infection. LVN 3 stated Resident 49 uses his left (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hand for holding the food during meals. LVN 3 stated having long and dirty fingernails is an infection control issue. LVN 3 stated she will inform the CNA to do nail care for Resident 49 as soon as possible. During an interview on 8/8/25 at 11:16 a.m. with the Director of Rehabilitation (DOR), the DOR stated she provided training to nursing staff regarding right hand hygiene and applying washcloth/palm protector to protect resident's palm for any injury. During a review of Resident 49's clinical record titled, Occupational Therapy: Weekly TEN Details, dated 6/3/25, Occupational Therapy: Weekly TEN Details indicated, .CNA trained in hand hygiene for skin integrity and use of washcloth or palm protector. During an interview on 8/13/25 at 4:20 p.m. with the Director of Nursing (DON), the DON stated her expectation for nursing staff to keep residents' fingernails cleaned and trimmed to prevent infection and skin injury. The DON stated nursing staff should follow and implement OT training about Resident 49's hand hygiene for skin integrity and use of washcloth or palm protector. During a review of facility's policy and procedure titled, Fingernails/Toenails, Care of, dated, 2/18, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching his or her skin.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to act upon reported drug regimen review irregularities when one of nine sampled residents (Resident 108) had suggested drug regimen updates and there was no action taken to address it or documentation as to why no change in medication was taken. This failure had the potential to lead to unresolved medication related issues and negative health outcomes of Resident 108. Findings: During a review of Resident 108'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 8/12/25, the AR indicated Resident 108 was admitted to the facility on [DATE] with diagnoses of heart failure (heart does not pump blood properly), atrial fibrillation (irregular heart rhythm), hypertension (high blood pressure), repeated falls, and schizophrenia (mental illness which affects ability to think, feel and behave clearly). During a review of Resident 108's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/13/25, the MDS indicated Resident 108 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 108 was cognitively intact. During a review of Resident 108's eMAR-Medication Administration Note, dated 7/22/25, the document indicated, . resident verbalized feeling dizzy. During a review of Resident 108's Consultant Pharmacist's Medication Regimen Review, dated 7/22/25, the document indicated Resident 108 sustained a fall on 7/22/25 and a medication regimen review was completed due to the change in condition. The document indicated, .change metoprolol [blood pressure medication used to lower high blood pressure] and amlodipine [blood pressure medication used to lower high blood pressure] hold parameters to hold for SBP [systolic blood pressure-pressure in arteries] < 110 [less than 100] (instead of 100). The document indicated metoprolol was a medium risk medication and amlodipine was a low-risk medication. The document was marked and signed by the provider as reviewed on 7/22/25. During a review of Resident 108's Order Summary Report, dated 8/12/25, the Order Summary Report (OSR) indicated, .amlodipine besylate oral tablet 5 MG [milligrams- unit of measurement to determine medication dose].give 1 tablet by mouth one time a day for hypertension hold medication is SBP <100, P [pulse-heart rate] < 60.active.start date 7/2/25. The OSR indicated, .metoprolol succinate ER [extended release-medication with delayed action] tablet extended release 24 hour 25 MG give 1 tablet by mouth one time a day for hypertension hold medication is SBP <100, P <60.active.order start date 7/24/25. During a concurrent interview and record review on 8/12/25 at 10:18 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 108's Electronic Medical Record (EMR- electronic medical record containing all pertinent health information), dated 8/12/25 was reviewed. LVN 6 stated Resident 108 sustained a fall on 7/22/25 which prompted a Change in Condition (COC-documents significant changes in a resident's health status, triggering a review of their care plan) report and a drug regimen review request, which was faxed to the Pharmacist Consultant (PC). LVN 6 stated the PC completed Resident 108's drug regimen review request on 7/22/25 and identified irregularities with recommendations for medication changes. LVN 6 stated the PC recommended, .change metoprolol and amlodipine hold parameters to hold for SBP < 110 (instead of 100). LVN 6 stated the provider, and the Director of Nursing (DON) were responsible to ensure drug regimen review recommendations were implemented or rationale was documented as to why drug regimen recommendations were not implemented. LVN 6 stated the provider signed and dated the drug regimen review on 7/22/25. LVN 6 stated Resident 108's metoprolol and amlodipine order had not (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been updated to reflect the PC's recommendations. LVN 6 stated she could not locate documented rationale as to why the recommendation was not implemented. LVN 6 stated licensed nursing staff were responsible to follow up on drug regimen review recommendations with the provider and the DON to ensure orders were updated or documentation was completed to provide a rationale as to why recommendations were not implemented. LVN 6 stated metoprolol and amlodipine decrease blood pressure and could have contributed to Resident 108 experiencing dizziness and a fall on 7/22/25. LVN 6 stated Resident 108 was at risk for increased or ongoing dizziness and falls with no follow-up on the drug regimen review recommendations. During a concurrent interview and record review on 8/12/25 at 10:45 a.m. with the Medical Records Supervisor (MRS), Resident 108's EMR, dated 8/12/25 was reviewed. The MRS stated medical record staff were responsible for uploading drug regimen reviews into the EMR. The MRS stated before uploading drug regimen reviews into the EMR medical records audited the form to ensure it was completed and intervention occurred. The MRS stated the recommendation would need an updated order or documentation rationale as to why the recommendation was not implemented before the drug regimen review was uploaded into the EMR. The MRS stated Resident 108 had a drug regimen review completed on 7/22/25 after she fell. The MRS stated Resident 108's orders did not reflect the PC's recommendations and there was no documentation as to why it was not implemented. The MRS stated the provider, the DON and licensed nursing staff were responsible to ensure drug regimen reviews were followed up on. The MRS stated medical records was responsible to ensure the drug regimen review was completed and followed up on before uploading it into the EMR. The MRS stated it was important to follow up on drug regimen reviews after a COC because it was needed following an event to identify potential contributing factors and without a follow-up Resident 108 was at risk for another fall. During a concurrent interview and record review on 8/12/25 at 3:45 p.m. with the PC, Resident 108's EMR, dated 8/12/25 was reviewed. The PC stated Resident 108 sustained a fall on 7/22/25 which prompted a drug regimen review. The PC stated blood pressure medication could have contributed to Resident 108's fall and recommendations were placed to adjust metoprolol and amlodipine hold parameters. The PC stated metoprolol and amlodipine medication orders had not been updated based on drug regimen review recommendations and he could not locate documentation as to why recommendations were not implemented. The PC stated licensed nursing staff and the provider were responsible to implement recommendations or document rationale as to why recommendations were not implemented. The PC stated the provider was not required to implement recommendations, but needed to provide documentation as to why interventions were not implemented based on drug regimen review. The PC stated drug regimen reviews were completed in response to a COC and required follow-up. During a concurrent interview and record review on 8/14/25 at 1:49 p.m. with the DON, Resident 108's EMR, dated 8/14/25 was reviewed. The DON stated when a COC occurred licensed nursing staff faxed a drug regimen review request to the PC. The DON stated it was important to complete drug regimen reviews after a COC to determine contributing factors to the event and prevent the event from occurring again. The DON stated the PC was responsible to complete drug regimen reviews. The DON stated licensed nursing staff, the provider, and herself were responsible to ensure recommendations were implemented or documentation was present as to why recommendations would not be implemented. The DON stated Resident 108 drug regimen review was completed after a COC on 7/22/25 and signed by the provider as reviewed, which indicated the provider agreed with the PC's recommendations. The DON stated resident 108's metoprolol and amlodipine order hold parameters had not be updated to reflect the PC's recommendations. The DON stated licensed nursing staff did not follow up with the provider to ensure metoprolol and amlodipine orders were updated. The DON stated Resident 108 was at risk for repeated dizziness, falls and injuries when her COC drug regimen review recommendations were not implemented as recommended by the PC and agreed upon by the provider. The DON stated proper medication management had not been implemented. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055147	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.			
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/2023, the P&P indicated, .the nurse will notify the resident's attending physician or physician on call when there has been a (an).need to alter the resident's medical treatment significantly.During a review of the facility's P&P titled, Medication Regimen Review, dated 5/2023, the P&P indicated, .the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication.the MRR involves a thorough review of the resident's medical record to prevent, identify, report, and resolve medication related problems. if the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action ahs ben taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator.the attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it.the staff member who identifies the change of condition follows reporting procedure to notify the physician.		

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

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of nine sampled residents (Resident 95) drug regimen was free from unnecessary drugs when Resident 95 received tramadol (opioid pain medication- a controlled substance used to treat moderate to severe pain) prescribed for pain management, despite reporting no pain. This failure resulted in over-medication and inadequate pain management practices of Resident 95 which had the potential to result in adverse consequences and complications which could lead to serious medical conditions. Findings: During a review of Resident 95'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 8/12/25, the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (condition in which brain tissue dies due to lack of blood flow), epilepsy (seizures due to abnormal brain activity), stiff-man syndrome (disorder which includes fluctuating muscle rigidity and spasms triggered by noise, touch, or distress), and major depressive disorder (persistent sadness). During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/22/25, the MDS indicated Resident 95 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 95 was cognitively intact. During a review of Resident 95's Order Summary Report, dated 8/12/25, the Order Summary Report indicated, .tramadol HCl oral tablet 50 MG (milligrams- unit of measurement for medication dosage) give 1 tablet by mouth every 8 hours for pain management. active.order date 5/23/24.start date 5/23/24. During a review of Resident 95's Medication Administration Record, dated 8/12/25, the document indicated from 6/1/25-6/30/25 tramadol was administered 74 times for a pain rating of 0 out of 10. The document indicated from 7/1/25-7/31/25 tramadol was administered 85 times for a pain rating of 0 out of 10. The document indicated from 8/1/25-8/11/25 tramadol was administered 29 times for a pain rating of 0 out of 10. During an interview on 8/7/25 at 1:54 p.m. with Resident 95 in Resident 95's room, Resident 95 stated, licensed nursing staff administered tramadol every day to her. Resident 95 stated her pain was well controlled with her other medications and had acetaminophen (pain medication used to treat mild to moderate pain) available as needed if she had breakthrough pain, which worked to manage her pain. Resident 95 stated she had received tramadol every day since admission. Resident 95 stated she did not need pain medication every day and would prefer not to take pain medication if she was not in pain. Resident 95 stated tramadol made her feel sleepy after administration. During a concurrent interview and record review on 8/7/25 at 3:05 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 95's Order Summary and Medication Administration Record (MAR), dated 8/7/25 was reviewed. LVN 1 stated Resident 95 had an active order for tramadol to be given .every 8 hours for pain management. LVN 1 stated tramadol was an opioid (a controlled substance that can become highly addictive) used to treat severe pain and would not be appropriate to be administered if Resident 95 had no pain. LVN 1 stated it was a professional standard to assess for pain prior to administration of routine, scheduled and as needed pain medication. LVN 1 stated the purpose of a pain assessment was to determine if pain medication was needed and which pain medication was most appropriate to administer. LVN 1 stated Resident 95 had been administered tramadol inappropriately when it was given for a recorded pain level of 0 out of 10 in 6/2025, 7/2025 and 8/2025. LVN 1 stated it was important to accurately assess and document pain levels to ensure the lowest most effective dose of pain medication was administered. LVN 1 stated Resident 95 was at risk for overmedication with the administration of tramadol with no reported pain. During an (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 8/12/25 at 3:45 p.m. with the Pharmacist Consultant (PC), the PC stated he was responsible for reviewing medication orders for appropriateness to ensure it was administered per the indication. The PC stated licensed nursing staff was responsible to complete pain assessments and administer the most appropriate pain medication based on the assessment. The PC stated all pain medication orders required a pain scale within the administration instructions to ensure pain medication was administered appropriately. The PC stated the administration of tramadol was not appropriate to be administered for a pain rating of 0 out of 10. During a concurrent interview and record review on 8/14/25 at 1:49 p.m. with the Director of Nursing (DON), Resident 95's Order Summary, and Medication Administration Record, dated 8/14/25 was reviewed. The DON stated tramadol was an opioid pain medication used to treat moderate to severe pain. The DON stated moderate to severe pain was considered 4 and above out of 10 on the pain scale. The DON stated according to facility policy and standard of practice a pain assessment was to be completed prior to all scheduled, routine, and as needed pain medication. The DON stated it was important to conduct a pain assessment to determine the most effective pain medication to administer or withhold and to monitor its effectiveness. The DON stated Resident 95 was at risk for overmedication or building up a pain medication tolerance to tramadol for inappropriate administration for a pain rating of less than 4 out of 10. The DON stated it was not appropriate to administer opioids when there was no reported pain. The DON stated it was not appropriate to administer tramadol 74 times between 6/1/25-6/30/25, 85 times between 7/1/25-7/31/25, and 29 times between 8/1/25- 8/11/25 for pain reports of 0 out of 10. The DON stated facility policy and pain management in-services had not been followed by licensed nursing staff when tramadol was administered for a pain rating of 0 out of 10. The DON stated Resident 95 was overmedicated and at risk for side effects such as, opioid dependency, increased pain tolerance threshold and constipation. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2023, the P&P indicated, .if a dosage if believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber , the resident's attending physician or the facility's medical director to discuss the concerns.During a review of the facility's P&P titled, Administering Pain Medications, dated 10/2022, the P&P indicated, .the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive car plan, and the resident's choices related to pain management.pain management is a multidisciplinary care process that includes the following.identifying and using specific strategies for different levels and sources of pain.modifying approaches as necessary.when opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. During a review of the facility's P&P titled, Pain Assessment and Management, dated 10/2023, the P&P indicated, .identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs.During a review of the facility's in -service meeting minutes document titled, Pain Level Monitoring and Documentation, dated 4/15/25, the in-service indicated, .if pain medication is ineffective or out of scale for pain medication, notify MD [medical doctor] immediately.entering (0) zero would be incorrect.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with the facility policy and procedures when:1. A box of Nicotine Transdermal Patches (a patch that released nicotine [a chemical found in tobacco] through the skin to help people stop smoking) were found in the Station 5 Medication Cart without a resident identifier on the box.This failure had the potential to cause a medication error and place residents at risk for receiving the wrong medication.2. An opened foil envelope packet of Budesonide inhalation suspension (a medicine that helped reduce swelling and irritation in the lungs) was found in the Station 5 Medication Cart without the date of opening written on the packet.This failure had the potential to compromise the integrity, potency and safety of the medication and placed residents at risk for receiving ineffective or unsafe treatment.3. An open bottle of iodine (a chemical used to clean and disinfect cuts, scrapes or skin to prevent infection) was found in the Station 5/6 Treatment Cart without the date of opening written on the container.This failure had the potential to affect the integrity and effectiveness of the solution and placed residents at risk for compromised infection control and unsafe treatment.4. Two opened tubes of 20% Zinc Oxide (an ointment used to protect the skin and prevent irritation and help treat rashes) were found in the Station 3 Treatment Cart without an open date.This failure had the potential to affect the integrity and effectiveness of the product and placed residents at risk of receiving compromised treatment.5. An opened tube of Phenylephrine Hemorrhoidal Ointment (a medicine used to relieve pain, itching and swelling in and around the anus) was found in the Station 3 Treatment Cart without a resident identifier on the tube itself.This failure had the potential to result in a medication error and placed residents at risk of receiving medication that was not prescribed for them.6. An opened tube of Hydrocortisone Acetate 1% (a cream used to reduce swelling, redness and itching of the skin) was found in the Station 3 Treatment Cart without an open date.This failure had the potential to affect the integrity and effectiveness of the medication and placed residents at risk for receiving compromised treatment.7. An opened tube of Muscle Rub Cream 10% menthol and 15% methyl salicylate topical analgesic (a topical medicine applied to sore muscles to help relieve pain and discomfort) was found in the Station 3 Treatment Cart without an open date.This failure had the potential to affect the integrity and effectiveness of the medication and placed residents at risk for receiving compromised treatment.8. An open tube of Diphenhydramine topical cream (topical medicine to relieve itching, redness or irritation caused by insect bites rashes or allergic reactions) was found in the Station 3 Treatment Cart without an open date.This failure had the potential to affect the integrity and effectiveness of the medication and placed residents at risk for receiving compromised treatment.9.Two opened tubes of 100% Medical Grade Manuka Honey (a special honey used on wounds and burns to help kill bacteria [germs] and promote healing) were found in the Station 3 Treatment Cart without open dates.This failure had the potential to affect the integrity and effectiveness of the medication and placed residents at risk for receiving compromised treatment.10. An unopened bottle of Lispro insulin (a fast-acting insulin to help control blood sugar levels) was found in the Station 1 Medication Cart, despite the packaging indicating it should be refrigerated until opened.This failure had the potential to compromise the effectiveness of the medication and placed residents at risk for receiving ineffective treatment.11. An opened bottle of carbamide peroxide 6.5% ear drops (a medicine used in the ears to help soften and remove ear wax safely) was found in the Station 2 Medication Cart without a resident identifier.This failure had the potential to result in a medication error and placed residents at risk of receiving medication that was not prescribed for them.Findings:1. During an observation on [DATE] at 9:29 a.m. a box of Nicotine Transdermal Patches was found in the Station 5 Medication Cart without a resident identifier on the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	box. During an interview on [DATE] at 10:35 a.m. with Licensed Vocational Nurse (LVN) 7, LVN 7 stated resident medications needed to be labeled with a resident identifier to ensure staff knew which resident they belonged to. During an interview on [DATE] at 4:23 p.m. with the Pharmacist Consultant (PC), the PC stated all resident medications were required to have a resident identifier to properly identify which resident the medication belonged to. During an interview on [DATE] at 10:59 a.m. with the Director of Nurses (DON), the DON stated medications should be labeled with a resident identifier to prevent them from being confused with another resident's medications. 2. During an observation on [DATE] at 10:19 a.m. an opened foil envelope packet of Budesonide inhalation suspension was found in the Station 5 Medication Cart without the date of opening written on the packet. The label indicated the medication was good for 14 days after opening. During an interview on [DATE] at 10:35 a.m. with LVN 7, LVN 7 stated medications needed to be labeled with an open date on the package to track how long they remained effective, noting that different medications had different expiration periods after opening. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated the medication remained effective for two weeks after opening and emphasized the importance of labeling it with the open date to ensure staff could accurately track its expiration. During an interview on [DATE] at 10:59 with the DON, the DON stated the expectation was for staff to record the date an item was opened to ensure its expiration date was accurately tracked. 3. During a concurrent observation and interview on [DATE] at 10:43 a.m. with LVN 7 at the Station 5 Nurses' Station, an opened bottle of iodine in the 5/6 Treatment Cart was not labeled with an open date. LVN 7 stated that bottles and other over-the-counter products (OTC) were required to be labeled with an open date so staff would know how long the item had been in use. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 4. During an observation on [DATE] at 8:55 a.m., two tubes of 20% Zinc Oxide were found in the Station 3 Treatment Cart without an open date. During an interview on [DATE] at 9:07 a.m. with LVN 5, LVN 5 stated the process was to date items when they were opened. LVN 5 stated it was important to know this information to ensure the product did not expire. LVN 5 further stated that all medications and OTCs in the treatment carts should be labeled with an open date. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 5. During an observation on [DATE] at 8:55 a.m., an opened tube of Phenylephrine Hemorrhoidal ointment was found in the Station 3 Treatment Cart without a resident identifier labeled on it. During an interview on [DATE] at 9:07 with LVN 5, LVN 5 stated the Hemorrhoidal ointment should have a resident identifier on it. LVN 5 explained it was important to ensure the product was labeled with a resident identifier because, when multiple residents had the same medication, it was necessary to know which tube belonged to each resident to prevent mix-ups. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated all medications should be labeled with a resident identifier to ensure the medication was assigned to the correct resident. The PC stated a risk to the residents would be medication mix-ups and potential cross contamination. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated medications should be labeled with a resident identifier. The DON explained that the tube is a separate item and should not be mixed up with another resident's medication, emphasizing that labeling the original box alone was not sufficient. 6. During an observation on [DATE] at 8:55 a.m., an (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opened tube of Hydrocortisone Acetate 1% cream found in Station 3 Treatment Cart without an open date. During an interview on [DATE] at 9:07 a.m. with LVN 5, LVN 5 stated the process was to date items when they were opened. LVN 5 stated it was important to know this information to ensure the product did not expire. LVN 5 further stated all medications and OTCs in the treatment carts should be labeled with an open date. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 7. During an observation on [DATE] at 8:55 a.m., an opened tube of Muscle Rub Cream 10% menthol and 15% methyl salicylate topical analgesic was found in the Station 3 Treatment Cart without an open date. During an interview on [DATE] at 9:07 a.m. with LVN 5, LVN 5 stated the process was to date items when they were opened. LVN 5 stated it was important to know this information to ensure the product did not expire. LVN 5 further stated that all medications and OTCs in the treatment carts should be labeled with an open date. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 8. During an observation on [DATE] at 8:55 a.m., an opened tube of Diphenhydramine topical cream was found in the Station 3 Treatment Cart without an open date. During an interview on [DATE] at 9:07 a.m. with LVN 5, LVN 5 stated the process was to date items when they were opened. LVN 5 stated it was important to know this information to ensure the product did not expire. LVN 5 further stated all medications and OTCs in the treatment carts should be labeled with an open date. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 9. Two opened tubes of 100% Medical Grade Manuka Honey were found in the Station 3 Treatment Cart without opened dates. During an interview on [DATE] at 9:07 a.m. with LVN 5, LVN 5 stated the process was to date items when they were opened. LVN 5 stated it was important to know this information to ensure the product did not expire. LVN 5 further stated all medications and OTCs in the treatment carts should be labeled with an open date. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated that all products, both OTC and prescription, were to be labeled with an open date. The PC stated this was important because every product has an expiration date, and it was necessary to know when that date would be. During an interview on [DATE] at 10:59 a.m. with the DON, the DON stated the expectation of staff was to place the date on items when they were opened. The DON explained that some medications were seldom used, and labeling helped ensure the medication was not expired. 10. During a concurrent observation and interview on [DATE] at 9:14 a.m. with Registered Nurse (RN) 3, an unopened bottle of Lispro insulin was found in the Station 1 Medication Cart. The label indicated that the insulin was to be refrigerated until used. RN 3 stated that because the cap was still on the bottle, the insulin had not been used and should have been stored in the refrigerator rather than in the medication cart. During an interview on [DATE] at 9:30 with Registered Nurse Supervisor (RNS), the RNS stated if medication was not stored properly, its effectiveness could be altered and that would be a risk to the resident. During an interview on [DATE] at 4:23 p.m. with the PC, the PC stated all (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility to provide food in a form to meet individual needs for two of 15 sampled residents (Resident 68 and 143) when:1. Resident 68 received hard toast for lunch on 8/5/25 while he was on a mechanical soft diet.2. Resident 143 was served hard toasted bread during lunch on 8/5/25. Resident 143 attempted to eat the hard toasted bread. Resident 143's prescribed diet was mechanical soft texture diet. These failures had the potential to place Resident 68 and 143 at increased risk of choking (is a blockage of the upper airway by food or other objects, which prevents a person from breathing effectively).1.During a review of Resident 68's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/25/25, the AR indicated, Resident 68 was admitted to the facility on [DATE] with the following diagnoses: unspecified sequel of cerebral infarction (the long-term effects or consequences of a stroke), muscle weakness (a reduced ability of one or more muscles to generate force), contracture of the left shoulder (a condition characterized by pain and stiffness in the shoulder), and dysphagia (medical condition characterized by difficulty swallowing). During a review of Resident 68's, Meal Ticket (document which outlines resident meal preferences, ordered diet, and allergies, undated, the Meal Ticket, indicated, .mechanical soft texture .During a review of Resident 68's, Order Summary Report, dated 8/13/25, the Order Summary Report indicated, . Order Summary . Fortified/high protein diet Mechanical soft texture .During a concurrent observation and interview on 8/5/25 at 12:16 p.m. with CNA 6, CNA 6 stated Resident 68 received burnt toast as part of his meal. CNA 6 stated Resident 68 should not have been given the piece of hard toast because he was on a mechanical soft diet, and he may have trouble eating it which could cause him to choke.During concurrent observation and interview on 8/5/25 at 12:16 p.m. with the Speech Language Pathologist (SLP), Resident 68's lunch tray had a slice of hard toast. The SLP stated Resident 68 was on a prescribed mechanical soft diet and the piece of hard toast on his plate should not have been provided. The SLP stated Resident 68 needed to receive softer slices of bread to be able to eat comfortably, he had not progressed enough to be able to adequately eat and swallow the toast.During an interview on 8/12/25 at 4:27 p.m. with the Infection Preventionist (IP), the IP stated she was checking meal trays before they were sent to the residents on Monday 8/5/25. The IP stated she checks the meal trays and compares them with the Meal Ticket in order to ensure the residents receive the correct meal in regard to meal preferences, special equipment, ordered diet, and food allergies. The IP stated she did not notice if the toast provided to Resident 68 was too hard, the kitchen staff should have noticed as well when they placed the food on the plates. The IP stated providing Resident 68 with the correct meal consistency would ensure he did not aspirate (inhaling a substance other than air into the lungs) or choke on his food if he tried to eat something he couldn't handle.During an interview with CNA 5, CNA 5 stated a mechanical soft diet is determine by the SLP, it is an evaluation to see what a resident can and can't swallow, if a resident gets an inappropriate diet they may have a hard time swallowing their food which would then put the resident at risk for choking. CNA 5 stated residents should never get the wrong diet.During an interview on 8/13/25 at 11:07 a.m. with the Director of Nursing (DON), the DON stated Resident 68 should have received his prescribed diet during lunch on 8/5/25. The DON stated kitchen and nursing staff were responsible for ensuring his mechanical soft diet was ordered; providing Resident 68 an appropriate diet he could consume ensured he could eat safely.During a concurrent interview and record review on 8/13/25 at 9:35 a.m. with the Certified Dietary Manager (CDM), Resident 68's Meal Ticket, undated, was reviewed. The Meal Ticket, indicated Resident 68 was on a mechanical soft diet. The CDM stated a person on a mechanical soft diet should not have received hard toast during their lunch, kitchen staff should have caught it during the trayline (food assembly system in a facility where food trays are (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prepared). The CDM stated Resident 68 had dysphagia and may have trouble eating the food if it wasn't the right consistency. During a review of the facility's P&P titled, Food and Nutrition Services, dated 10/17, the P&P indicated, . 7. Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident . 2.During a concurrent observation and interview on 8/5/25 at 12:12 p.m. with Resident 143, in the dining room, Resident 143 was sitting up in a wheelchair, eating her lunch meal under Restorative Nursing Aide (RNA) 1's supervision. Resident 143 was touching the toasted bread and stated it was hard. Resident 143 stated she loves soft bread. Resident 143 stated she had blindness (lack of usable vision) on both eyes and stated, I can only see shadow. During a concurrent observation and interview on 8/5/25 at 12:13 p.m. with RNA 1, in the dining room, RNA 1 was assisting and guiding Resident 143 while eating. RNA 1 was tapping the toasted bread with a fork and stated the toasted bread was hard as a rock. RNA 1 stated Resident 143 was served with a hard toasted bread. RNA 1 stated the bread was too hard and stated, this is not a mechanical soft bread. Resident 143 should be on a mechanical soft diet. RNA 1 requested three times to the kitchen to change the toasted bread into a mechanical soft bread. RNA 1 stated the kitchen replaced the toasted bread to a puree bread two times until the kitchen served the appropriate mechanical soft bread on her third request. RNA 1 stated Resident 143 can choke because the bread was too hard to chew. During an interview on 8/8/25 at 11:16 a.m. with the Director of Rehabilitation (DOR), the DOR stated the SLP reported to her that two residents on mechanical soft texture were served with toasted bread. The DOR stated the SLP verified the toasted bread was hard as a rock.During an interview on 8/8/25 at 11:44 a.m. with the SLP, the SLP stated Resident 143 was on Mechanical soft texture diet due to chewing problem. SLP stated Resident 143 was edentulous. SLP stated mechanical soft texture diet should be followed to prevent Resident 143 from choking, SLP stated if a resident is not able to chew the food, resident will have difficulty swallowing and placed residents at higher risk of choking. SLP stated the resident's appropriate diet texture and consistency was based on resident assessment and treatments.During an interview on 8/8/25 at 2:15 p.m. with the Director of Nursing (DON), the DON stated resident's diet should be followed as prescribed by the physician to prevent choking and resident will receive proper nutrition and hydration. The hard toasted bread was not a mechanical soft diet and stated Resident 143 can choke.During a review of Resident 143's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/14/25, the AR indicated, Resident 143 was admitted to the facility on [DATE] with the following diagnoses: Unspecified Dementia(a progressive state of decline in mental abilities), Polyneuropathy (a condition in which a person's peripheral nerves are damaged), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and Essential Hypertension (HTN-high blood pressure).During a review of Resident 143's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/1/25, the MDS section C indicated Resident 143 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 7 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 143 was severely impaired.During a review of Resident 44's, electronic medical record (EMR- a digital version of a patient's paper chart) titled, Order Summary Report, dated 8/14/25, the Order Summary Report indicated, . Dietary - Diet Order Summary . Mechanical Soft/Chopped meat texture.During a review of Resident 6's EMR titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, .The resident has a nutritional problem. Interventions: .Provide and serve diet as ordered: .Mechanical Soft/chopped meat texture.During an interview on 8/13/25 at 4:42 p.m. with the Registered Dietitian (RD), the RD stated residents should not be served with hard toasted bread if on Mechanical soft texture diet, it should be sent back to the kitchen to replace with the right texture diet. During a review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 10/17, the P&P indicated, .7. Food and (continued on next page)		

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

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Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER Madera Rehabilitation & Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 517 South A Street Madera, CA 93638	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident .		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:nineNumber of residents cited:oneBased on observation, interview and record review, the facility failed to follow the policy and procedure (P&P) for Foods Brought by Family/Visitors for one of nine sample residents (Resident 49) when perishable food (food that spoil, decay, and unsafe to eat if not stored properly) was stored in Resident 49's bedside table. This failure had the potential for Resident 49 at an increased risk of acquiring food-borne illnesses (referred to as food poisoning, are caused by eating or drinking something that is contaminated with germs/spoiled). During a concurrent observation and interview on 8/5/25 at 11:02 a.m. with Resident 49, in Resident 49's room, Resident 49 was lying in bed. Resident 49 was awake with slurred (indistinct and difficult to hear or understand) speech and was able to respond during conversation by nodding his head using yes and no questions. Resident 49 was unable to move his right upper extremity and right lower extremity. Resident 49 moved his left hand towards the left side of the bed. Resident 49's right hand was elevated with pillow; right hand was closed in a fist (a hand with a finger s clenched in the palm) position with minimal swelling. Resident 49 was unable to open his right hand. Resident 49's bedside table contained a container of fresh strawberries, undated, with multiple and scattered black spots on the strawberries and an opened bottle of orange juice without an open date.During a review of Resident 49's MDS, dated [DATE], the MDS section C indicated Resident 49's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 49's BIMS Summary Score was blank.During a review Resident 49's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 8/14/25, the AR indicated Resident 49 was admitted to the facility on [DATE] with diagnosis of Hemiplegia (paralysis on one side of the body) and hemiparesis (muscle weakness on side of the body) following Cerebral Infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting right dominant side, Aphasia following Cerebral Infarction, Dysphagia(difficulty swallowing) following Cerebral Infarction, Dysarthria (difficulty speaking due to weak speech muscles) following Unspecified Cerebrovascular Disease (loss of blood flow to a part of the brain), Contracture (is tightening and shortening of the surrounding soft tissues which then restrict joint [a connection of two bones in the skeletal system] movement). of Muscle Right Hand, and Contracture, Unspecified Joint.During an interview on 8/6/25 at 12:16 p.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 49's family brings food on weekly basis and replaced previously brought food every week. CNA 11 stated food brought by Resident 49's family was stored in Resident 49's bedside table. CNA 11 stated she threw a container of rotten (can appear moldy, diseased, or dried out, and may be infested with insects) fresh strawberries with scattered black spots on the strawberries yesterday afternoon (5/5/25). CNA 11 stated, I don't want my family member eating a rotten food. CNA 11 stated Resident 49 can get sick when rotten strawberries were eaten by Resident 49. CNA 11 stated fresh strawberries should be stored in the refrigerator not at the bedside table. CNA 11 stated the facility had no refrigerator for the residents. During a concurrent observation and interview on 8/6/25 at 4:30 p.m. with the Licensed Vocational Nurse (LVN) 2, in Resident 49's room, LVN 2 checked Resident 49's bedside table and opened the first drawer. LVN 3 stated the bottle of orange juice on the top of the bedside table was opened and undated. LVN 3 stated there were fresh fruits such as three oranges, one apple, and a bag of grapes stored in Resident 49's first drawer of the bedside table. LVN 2 stated Resident 49's drawer was dirty with bread crumbs and sticky paste like juice. LVN 2 stated perishable food like fresh fruits should be stored in a refrigerator and should be labeled and dated. LVN 2 stated the facility had a resident refrigerator located in Station 5. LVN 2 stated Resident 49 can get sick when consumed perishable food that requires refrigeration (involves keeping foods at safe temperatures to slow bacterial growth and prevent food borne illnesses). During an interview on 8/14/25 at 1:53 p.m. with the Director of Nursing (DON), the DON stated perishable (continued on next page)		

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Form Approved OMB
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	food items brought by family should be stored in the refrigerator, labeled and dated to prevent food-borne illnesses. The DON stated Resident fresh fruits like strawberries should be stored in the refrigerator. During the review of facility's P&P titled, Food Brought by Family/Visitors, dated 3/24, the P&P indicated, Food brought to the facility by visitors and family is permitted. Facility staff will strive to balance resident choice and a homelike environment with the nutritional and safety needs of residents. Policy Interpretation and Implementation. 5. Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that is clearly distinguishable from facility-prepared food. B. Perishable foods are stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers are labeled with the resident's name, the item and the use by date. 6. The nursing staff will discard perishable foods on or before the use by date.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to establish and maintain an infection prevention and control program to provide a safe and sanitary environment to prevent infections for one of four sampled residents (Resident 13) when Resident 13's handheld nebulizer tubing (device that delivers medication into fine mist directly into the lungs) had a date of 7/17/25. This failure had the potential to put Resident 12 at risk for possible respiratory infection. During an observation on 8/5/25 at 10:01 a.m. during initial tour in Resident 13's room, Resident 13 was not in his room. Observed a handheld nebulizer at bedside inside a plastic bag a handheld nebulizer tubing dated 7/17/25. During a review of Resident 13's admission Record, dated 8/8/25, the admission record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (one sided weakness or partial paralysis), depression (feeling of persistently sad and hopeless, impacting ability to enjoy life and carry out daily activities), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing and unspecified atrial fibrillation (heart upper chambers beat irregularly and often rapidly) and muscle weakness. During a review of Resident 13's Order Summary Report, dated 8/8/25, the Order Summary Report, indicated, .Ipratropium-Albuterol [medication used to treat and prevent wheezing and shortness of breath] Inhalation solution 0.5-2.5 (3) MG[milligram-unit of measurement]/3ML [milliliter-unit of measurement] (Ipratropium-Albuterol) 3 ml inhale orally three times a day. Start Date: 4/18/25. During a concurrent observation and interview on 8/5/25 at 12:03 p.m. with Registered Nurse (RN) 5 in Resident 13's room, RN 5 stated the handheld nebulizer tubing had a date of 7/17/25. RN 5 stated the practice was to change the tubing every week. RN 5 stated Resident 13's handheld nebulizer tubing should have been changed at the same time when oxygen tubing's were changed. RN 5 state it was an infection control issues, bacteria could grow inside the tubing and when used could go straight to the lungs causing more health issues. During a concurrent interview and record review on 8/12/25 at 1:40 p.m. with Licensed Vocational Nurse (LVN) 9, LVN 9 reviewed Resident 13's medication orders and stated Resident 13's ipratropium-albuterol was given three times a day via nebulizer machine. LVN 9 stated nebulizer tubing are changed every week. LVN 9 stated the nebulizer tubing should have been changed, it was an infection control issue. LVN 9 stated bacteria could grow in the nebulizer tubing and resident can inhale the bacteria. During an interview on 8/14/25 at 8:45 a.m. with the Infection Preventionist (IP), the IP stated oxygen tubing and handheld nebulizer tubing are changed every week on Thursdays and as needed. The IP stated handheld nebulizer of Resident 13 should have been changed on 7/24/25 and 7/31/25 but it was not. The IP stated it is an infection control issue not having changed the handheld nebulizer tubing, bacteria could grow inside the tubing causing infection to residents. The IP stated it was the responsibility of all licensed nurses to make sure handheld tubing are changed weekly and as needed. During an interview on 8/14/25 at 10:05 a.m. with Director of Nursing (DON), the DON stated her expectation was for licensed nurses to ensure all oxygen and handheld nebulizer tubing are changed weekly and as needed. The DON stated not changing tubing could cause infection which could result to serious health issues. During a review of facility policy and procedure (P&P) titled, Oxygen Administration, dated 2/24, the P&P indicated, .Verify that there is a physician's order for this procedure. Review the physician's orders. Documentation: The date and time that the procedure was performed. The frequency and duration of the treatment. How the resident tolerated the procedure.		

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation during the survey period of 8/5/25 to 8/14/25, the facility failed to provide and maintain minimum square footage for each resident in 33 of 74 rooms (Rooms 16, 17,18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35,38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50) During an observation of the facility on 5/19/19 to 5/23/19, the following rooms did not provide the minimum square footage as required by the regulation: Rooms 16, 17,18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35,38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, and 50. The residents had a reasonable amount of privacy. Closets and storage spaces were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents. Room # Square Feet # Residents 16 219 317 222 318 222 319 217 320 143 221 140 222 143 223 140 224 142 225 144 226 144 227 144 228 145 229 143 230 145 231 148 232 234 333 223 334 215 335 142 238 142 239 207 3 40 139 241 207 342 140 243 210 344 143 245 211 346 141 247 208 348 138 249 212 350 209 3 Recommend waiver continue in effect. _____ Health Facility Evaluator Nurse / Date Request continuance of waiver. _____ Administrator Signature / Date		