STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055283	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
John C. Fremont Healthcare District Dp/Snf	5189 Hospital Road Mariposa, CA 95338

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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 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** 48739 Based on observation, interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan (CP -a detailed approach to care customized to an individual resident's needs) for two of five residents (Residents 10 and 14) when Residents 10 and 14 did not have a CP for the used of anti-coagulation medication (medication that prevents blood clots from forming) to monitor for side effects such as bleeding and bruising. This failure had the potential to place Resident 10 and Resident 14 at risk for signs and symptoms of bleeding to go unidentified. Findings: During an observation on 8/6/24 at 10:59 a.m. in Resident 10's room, Resident 10 was observed dressed, sleeping in bed. No bruising or bleeding was observed on Resident 10. During a review of Resident 10's Admission Records (AR- contains information that helps the healthcare team understands patient's health status and provide tailored care), dated 8/8/24, the AR indicated Resident 10 was admitted on [DATE] with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), hyperlipidemia (a condition where fats build up in the arteries, increasing the risk of a stroke [a condition when a blood vessel that carries oxygen and nutrients to the brain is either blocked or ruptures]or heart attack [a condition with the blood flow that brings oxygen to the heart is severely reduced or blocked]), and history of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain) and cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 10's Minimum Data Set (MDS-standardized assessment tool that measures health status in nursing home residents), dated 7/12/24, the MDS section C indicated Resident 10 had a Brief Interview for Mental Status (BIMS- an assessment used in nursing homes to monitor cognition) score of zero, indicating Resident 10 had severe cognitive impairment. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/8/24 at 1:36 p.m. with the Director of Staff Development (DSD), Resident 10's CP, dated 8/8/24 was reviewed. The CP indicated Resident 10 did not have a CP for the used of anticoagulant medication. The DSD stated Resident 10 should have had a CP in place to monitor for bleeding or bruising. The DSD stated Resident 10 did not have an individualized CP for the used of anticoagulant medication. During a review of Resident 10's PO, dated August 2024, the PO indicated, . aspirin [medication used to reduce the risk for blood clot formation] 81 mg [milligrams- units of measurement] EC [enteric coated- a protective layer applied in oral medications to prevent from dissolving in the stomach's acidic environment] tablet 1 tab by mouth daily Hx [history] of CVA [cerebrovascular accident- occurs when blood flow to the brain is interrupted, cause by broken blood vessels or blood clots] . During an observation on 8/6/24 at 11:04 a.m. in Resident 14's room, Resident 14 was observed dressed sitting in an electric wheelchair, leaning back, and sleeping wearing headphones. No bleeding or bruising was observed on Resident 14. During a review of Resident 14's AR, dated 8/8/24, the AR indicated Resident 14 was admitted on [DATE] with diagnoses of paraplegia (paralysis [the loss of the ability to move and sometimes to feel anything] that occurs in the lower half of the body), atrial fibrillation (A-fib - an irregular and often very rapid heart rhythm) and essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition). During a review of Resident 14's MDS, dated [DATE], the MDS section C indicated Resident 14 had a BIMS score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 14 was cognitively intact. During a concurrent observation and interview on 8/6/24 at 12:30 p.m. with Resident 14 in the hallway, Resident 14 was observed eating his meal sitting with licensed vocational nurse (LVN) 1. Resident 14 stated he had no bruising or bleeding. During a concurrent interview and record review on 8/6/24 at 4:02 p.m. with the DSD, Resident 14's Physicians Orders (PO), dated 8/2024, was reviewed. The PO indicated . Apixaban [medication used to reduce the risk for blood clot formation] 5 mg tablet 1 tab by mouth twice daily. DX [diagnosis]: A-Fib . The DSD stated there was no order to monitor anticoagulation medication side effects such as bleeding. During a concurrent interview and record review on 8/8/24 at 1:39 p.m. with the DSD, Resident 14's Care Plan (CP), dated 8/8/24 was reviewed. The CP indicated Resident 14 did not have a CP in place to monitor side effects of anticoagulant medication used such as bleeding or bruising. The DSD stated Resident 14 should have a CP for the used of anticoagulation medication to monitor for bleeding and bruising. (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 8/8/24 at 2:42 p.m. with the Director of Nursing (DON), the DON stated the DON was ultimately responsible for making sure residents CPs were completed. The DON stated her expectation was for CPs to be current and not outdated. The DON stated CPs were important because it helps guide nursing staff on how to provide consistent individualized care to residents. The DON stated Resident 10 and Resident 14 should have a CP initiated for the used of anticoagulation medication to help monitor for side effects such as bleeding and bruising. During a review of the facility's policy and procedure (P&P) titled, Goals and Objectives, Care Plans, dated 2021 indicated, . care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence . care plan goals and objectives are derived from information contained in the resident's comprehensive assessment . are resident oriented . goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved . During a review of the P&P titled, Care Plans, Comprehensive Person-Centered, dated 2021, indicated . the comprehensive, person-centered care plan: . describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . reflects currently recognized standards of practice for problem areas and conditions . During a review of the facility's job description (JD) titled, MDS Coordinator/RN, dated 11/28/17, indicated, . employee's primary responsibility is to conduct and coordinate the development and completion of the resident's assessments/care plans . completes preliminary and comprehensive assessments of the nursing needs of each resident . appropriately coordinates the development of a written plan of care (preliminary and comprehensive) for each resident that identifies the problems/needs of the resident, indicates the care to be given, goals to be accomplished . assists . in ensuring that all personnel involved in providing care to the resident are aware of the resident's care plan that nursing personnel refer to resident's care plan prior to administering daily care to the resident . During a review of the facility's JD titled, LVN, Level I, II, III, dated 1/13/17, indicated, . major duties and responsibilities . reads and signs Care Plans . writes and updates long and short-term care plans . During a review of the facility's JD titled, Director of Skilled Nursing, dated 10/1/19, indicated . major duties and responsibilities: . assures that the nursing process is carried out (comprehensive assessments, care planning and documentation) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on interview and record review, the facility failed to provide services which met professional standards of practice when: 1. License Vocational Nurse (LVN) 1 during medication administration failed to inform facility residents the names and indications of the medications they are taking for three of eight sampled residents (Resident 3, 6, and 11). This failure had the potential risk for Resident 3, Resident 6, and Resident 11 to not understand the importance of their medication regimen and feelings of being not in control of their health and wellbeing which could lead to noncompliance. 2. Certified Nurse Assistant (CNA) 1's CNA certification expired on [DATE] and the facility scheduled CNA 1 to work and provide direct patient care from [DATE] to [DATE]. This failure had the potential risk to place all facility residents to received unsafe and poor quality of care. Findings: 1. During a medication pass observation on [DATE], at 12:07 p.m., inside Resident 3's room, LVN 1 administered Acetaminophen (medication use for generalized pain or discomfort) 325 mg (milligram, unit of measurement) 2 tablets (650 mg) and Lithium carbonate (medication use to stabilize the mood and extreme behaviors) 150 mg one capsule without explaining the medication and indication to Resident 3. During a review of Resident 3's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated [DATE], the AR indicated, Resident 3 was admitted from an acute care hospital on [DATE] to the facility, whose diagnoses included Bipolar disorder (a mental condition marked by alternating periods of joy and depression), Hypertension (high blood pressure), History of Falling, Weakness, and Insomnia (difficulty sleeping). During a review of Resident 3's Order Summary Report (OSR), dated [DATE], the OSR indicated, . ACETAMINOPHEN 325 MG TABLET 2 TABS (650 MG) BY MOUTH TWICE DAILY FOR PAIN . Order date [DATE] . LITHIUM CARBONATE 150 MG CAPSULE: 1 capsule by mouth three times every day . Dx [Diagnosis]: Bipolar Disorder . Order date [DATE] . During a medication pass observation on [DATE], at 12:10 p.m., inside Resident 11's room, LVN 1 administered Carbidopa-Levodopa (medication for Parkinson's Disease, a disease of the brain and spinal cord) ,d+[DATE] mg 1 tablet without explaining the medication and indication to Resident 11. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 11's AR, dated [DATE], the AR indicated, Resident 11 was admitted from an acute care hospital on [DATE] to the facility, whose diagnoses included Parkinson's Disease, Muscle Weakness, Type 2 Diabetes Mellitus (disorder of blood sugars), and Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 11's OSR, dated [DATE], the OSR indicated, . CARBIDOPA-LEVODOPA ,d+[DATE] TAB ONE TAB BY MOUTH THREE TIMES A DAY DX: PARKINSON'S DISEASE . Order date [DATE] . During a medication pass observation on [DATE], at 1:52 p.m., inside Resident 6's room, LVN 1 administered Calcium Carbonate 500 mg 1 tablet, Sennosides Laxative (medication to prevent constipation) 1 tablet, Polyethylene Glycol powder (medication to prevent constipation) 17 grams mix with 4 ounce of water, Vitamin D3 (ergocalciferol, supplement that helps the body to absorb calcium and phosphorous) 2000 units 1 tablet, Divalproex sodium ER (medication to treat mood episodes and depression) 125 mg 1 capsule, and Hydrocodone-Acetaminophen ,d+[DATE] mg 1 tablet without explaining the medications and indications to Resident 6. During a review of Resident 6's AR, dated [DATE], the AR indicated, Resident 6 was admitted from an acute care hospital on [DATE] to the facility, whose diagnoses included Dementia (impaired ability to remember, think, or make decisions), Hypertension, Chronic Pain (pain longer than six months), Muscle Weakness, Constipation, Osteoarthritis (degenerative disease of the bone joints that worsens over time, often resulting in chronic pain), and Major Depressive Disorder. During a review of Resident 6's OSR, dated [DATE], the OSR indicated, . CALCIUM CARBONATE 500 MG 1 TABLET DAILY . Order date [DATE] . SENNOSIDES LAXATIVE TABLET 1 TABLET BY MOUTH TWICE DAILY . Order date [DATE] . POLYETHYLENE GLYCOL POWDER 17 GRAMS MIX WITH 4 OUNCE OF WATER . Order date [DATE] . VITAMIN D3 2000 UNITS 1 TABLET BY MOUTH DAILY . Order date [DATE] . DIVALPROEX SODIUM ER 125 MG 1 CAPSULE BY MOUTH TWICE A DAY . Order date [DATE] . HYDROCODONE-ACETAMINOPHEN ,d+[DATE] MG 1 TABLET BY MOUTH THREE TIMES A DAY . Order date [DATE] . During an interview on [DATE], at 2:10 p.m., with LVN 1, LVN 1 stated she did not explain the medications and indications when she gave the medications to Residents 3, 6, and 11. LVN 1 stated facility residents had the right to know the medications they are receiving, and she failed to inform Resident 3, Resident 6, and Resident 11. During an interview on [DATE], at 10:07 a.m. with the Director of Nursing (DON), the DON stated LVN 1 should have explain the medications and their use prior to medication administration. The DON stated facility Residents had the right to know the medications they are taking. The DON stated LVN 1 failed to follow the facility's expectations and assigned responsibilities during medication pass. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, dated , d+[DATE], the document indicated, . Job Summary: Employee administers appropriate nursing care to residents in the skilled nursing facility . Performs a variety of direct and indirect patient care duties and activities . D. Essential Skills . 14. Understanding of the principles and practices of licensed vocational nursing. 15. Understanding of the pharmaceuticals prescribed for the elderly, and has knowledge of actions of medications and their side effects . During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated , d+[DATE], the P&P indicated . Medications are administered in a safe and timely manner, and as prescribed . 5. Medication administration times are determined by resident need and benefit . c. honoring resident choices and preferences, consistent with his or her care plan . 2. During a concurrent interview and record review on [DATE], at 2:22 p.m., with the Director of Staff Development (DSD), the facility document titled, CNA 1's Personnel File, undated was reviewed. The DSD stated CNA 1 was hired on [DATE] and her annual evaluation was completed and signed on [DATE]. The DSD stated CNA 1's CNA certification expired on [DATE] and she did not find a copy of CNA 1's active CNA certification. The DSD stated the facility failed to ensure CNA 1's CNA certificate was active prior to scheduling her to work on [DATE]. The DSD stated CNA 1 was working and providing care to facility residents with an expired CNA certification from [DATE] to [DATE]. The DSD stated the failure had the potential to place facility residents at risk of receiving unsafe care from CNA 1. During a concurrent interview and record review on [DATE], at 2:35 p.m., with the DON, the facility document titled, CNA 1's Personnel File, undated was reviewed. The DON stated CNA 1's CNA certification expired on [DATE] and she did not find a copy of CNA 1's active CNA certification. The DON stated she completed and signed CNA 1's annual evaluation on [DATE] and failed to obtain a copy of CNA 1's active CNA certificate prior to scheduling her to work on [DATE]. The DON stated the failure had the potential to place facility Residents at risk of receiving unsafe care from CNA 1. During a review of the facility's document titled, Job Description: Certified Nurse Assistant, dated ,d+[DATE], the document indicated, . Job Summary: Employee performs various non-professional patient/resident care duties in the skilled nursing department. Maintains and operates hospital and nursing equipment, provides bedside care and assists in the treatment of patients Minimum Qualifications . 2. Successful completion of nursing assistant course . B. Follows District and Skilled Nursing Department policies and procedures . 8.1 Demonstrates and understanding of policies, procedures, State and Federal regulations . During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing, dated ,d+[DATE], the P&P indicated . Our facility provides sufficient numbers of nursing staff with the appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and facility staff . Nurse aides are individuals providing nursing or related services to residents in the facility .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on interview and record review, the facility failed to ensure a Registered Nurse (RN) was scheduled and in the facility for at least eight consecutive hours a day, seven days per week, when the facility did not have an RN scheduled to work on weekends (Saturday and Sunday), from [DATE] to [DATE]. The facility did not provide documented evidence of Center for Medicare and Medicaid (CMS-is a federal government agency) approved waiver for this requirement. This failure resulted in an inadequate RN facility staffing and the potential for residents to have their medical needs to go unrecognized by an RN and the potential for serious medical consequences to occur. Findings: During a concurrent interview and record review on [DATE], at 9:14 a.m., with Director of Staff Development (DSP), the facility document titled, Monthly Staff Schedule, dated from [DATE] to [DATE] was reviewed. The DSD stated she had been at the facility since [DATE] and the facility did not have an RN coverage on weekends. The DSD stated the facility had an RN waiver from CMS that expired in February 2024. The DSD stated the DON who is a Registered Nurse served as a Charge Nurse, from Monday to Friday. The DSD stated the facility has 16 licensed beds and currently on full capacity. The DSD stated RNs were necessary when residents needed intravenous (IV) medication or an in-depth assessment. During an interview on [DATE], at 3:55 p.m., with the Director of Nursing (DON), the DON stated she worked as a fulltime DON, 40 hours a week, Monday to Friday, and the designated Charge Nurse for the Skilled Nursing Facility (SNF). The DON stated they do not have a Registered Nurse to work on weekends for several years. The DON stated the facility had an RN waiver from CMS but it expired in February 2024. The DON stated RNs were necessary when residents needed in-depth assessment due to change in condition or treatments requiring intravenous drugs. During a review of the facility's document titled, Monthly Staff Schedule dated from [DATE] to [DATE], the staff schedule indicated no RN scheduled to work for the following days: February 2024 [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] [DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE] and [DATE] (16 hours) [DATE] and [DATE] (16 hours) [DATE] [DATE] and [DATE] (16 hours) During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing dated ,d+[DATE], the P&P indicated, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment . 1. Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services . 2. A licensed nurse is designated as a charge nurse on each shift . c. The director of nursing services (DNS) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer residents . 3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident . During a professional reference review retrieved from https://cmscompliancegroup.com titled, F727 RN 8 Hours/7 days/Week, Full Time DON dated ,d+[DATE], the professional reference indicated, . The regulation states that unless a waiver is in place: A facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. The facility must designate a registered nurse to serve as the director of nursing on a full-time basis (35 or more hours per week). The Interpretive Guidance states that the DON requirement can be fulfilled by using two or more RNs so long as the roles and responsibilities for all RN staff serving as the DON are clearly defined and facility staff understand how the responsibilities are shared. The director of nursing may only serve as a charge nurse when the facility's average daily census is 60 or fewer residents .