

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055283	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/10/2026
NAME OF PROVIDER OR SUPPLIER John C. Fremont Healthcare District Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 5189 Hospital Road Mariposa, CA 95338	
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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure dietary services were directed by a qualified Certified Dietary Manager (CDM) for 15 of 15 residents, when the facility CDM's certification expired on 6/1/25. This failure resulted in a lack of oversight by a qualified Certified Dietary Manager, which had the potential risk to affect food safety, infection control practices, and the nutritional well-being of residents. Findings: During an interview on 2/6/26 at 8:35a.m. with the Cook, the [NAME] stated the CDM was her supervisor and all kitchen staff reported to the CDM. The [NAME] stated the CDM conducted all training for the kitchen staff. During an interview on 2/6/26 at 8:39a.m. with the CDM, the CDM stated her CDM license had lapsed on 6/1/25. The CDM stated she was required to submit all continuing education hours to the certifying board of dietary managers (CBDM) by 5/31/25 and her license was required to be renewed every three years. The CDM stated she reported to the Infection Preventionist (IP), who had been her supervisor for the past several months. The CDM stated in November the IP requested a copy of her renewed license; however, they were unable to connect to review it at that time. The CDM stated in January, the IP asked her to verify her license status online in the IP's presence, at which time the license status reflected as expired. The CDM stated she had since paid the required fee to retake the CDM examination to renew her license and the examination was scheduled for the end of the month. During an interview on 2/6/26 at 9:33a.m. with the Registered Dietitian (RD), the RD stated he did not oversee the kitchen and the CDM was responsible for kitchen operations. The RD stated he had recently become aware the CDM's license was expired. During an interview on 2/6/26 at 11:38a.m. with the IP, the IP stated the issue began in November 2025 when the Director of Nursing (DON) brought forward a concern regarding the CDM's license, noting that the CDM had not provided her certification during the last recertification survey. The IP stated she asked the CDM about her license approximately one month ago. The IP stated the CDM informed her the previous week she was short of two CEU's needed for renewal. The IP stated upon learning this information, she immediately notified the Administrator and Human Resources (HR) to determine how to address the situation. The IP stated her understanding was that HR tracked employee licenses and certifications; however, she now understood that she had a role in oversight. The IP stated the CDM's responsibilities included assisting in ensuring meals were nutritionally balanced, overseeing infection control and food safety practices, supervising kitchen staff to ensure safe operations, participating in the interdisciplinary team (IDT) and completing resident preference documentation. The IP stated an active certification was necessary to ensure the individual remained current with required education, standards and regulatory changes. The IP stated employees were ultimately responsible for maintaining their credentials and that she was unsure whether HR had issued reminder notifications to the CDM. During a review of Dietary Manager Job Description, dated 2019, indicated, 3. Successful completion of a dietetic supervisor's training program meeting requirements of education program acceptable to the State of California Department of Health Service. Knowledge of Federal, State and County laws, rules and regulations relating to dietetic service and management. Follows District and Departmental (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: 055283
		If continuation sheet Page 1 of 21

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	policies and procedures. Always distributes and follows-up on personnel requests to employees for current license, certifications, physicals, and other information requests. Remains aware of expirations dates, and removes employee from schedule when necessary. During a review of the facilities policy and procedure (P&P) titled, License/ Certifications, dated 5/1/2019, the P&P indicated, It is the policy of [NAME] C. [NAME] Healthcare District that employees whose jobs require that they be licensed or certified by the State, Federal Government or professional organization shall be expected to maintain a current license/certification at all times and are responsible any fees and for fulfilling the educational requirements for renewal of said licenses/certifications. Employees are expected to present their current licenses/certifications to the Human Resources Department and to their Department Manager. A copy of the license/certification will be maintained in the employee's personnel file.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement and maintain an effective infection prevention and control program when: 1. The Environmental Services Staff (EVSS) failed to handle, store, and process residents' personal clothing to prevent the spread of infection. 2. The facility's written policies and procedures (P&P) for infection prevention and control program (IPCP) -a set of facility's policies and procedures aimed at preventing the spread of infection) was not reviewed annually by the infection control committee members with last reviewed date of 3/8/23. These failures placed residents at risk for cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect), spread of infectious diseases resulting in healthcare associated infections, and systemic infection control breakdown due to lack of annual program review. 1. During a concurrent observation and interview on 2/6/26 at 8:51 a.m. with Licensed Vocational Nurse (LVN) 2, in the laundry room, the dirty hamper was widely open with overflowing of bagged soiled and dirty residents' personal clothing, and a container of cookies was on the top of the counter. LVN 2 stated the dirty hamper should not be overflowing and should remain closed to prevent cross contamination from dirty to clean items. LVN 2 stated clean and dirty clothing was stored in the same room. LVN 2 stated food should not be stored in the laundry room. During an interview on 2/6/26 at 11:14 a.m. with the Infection Preventionist (IP), the IP stated Environmental Services (EVS) is responsible in facilitating laundry services for all residents' personal clothing. The IP stated it was her expectation to keep the lids of dirty hampers always close when not being accessed by staff. The IP stated the dirty hampers should not be overflowing with dirty clothing and bagged soiled clothing to prevent cross contamination. The IP stated food should not be stored in the laundry room to prevent potential risk of cross-contamination. During an interview on 2/6/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated food was not allowed inside the laundry room to prevent cross contamination. During a concurrent observation and interview on 2/10/26 at 9:13 a.m. with Environmental Services Staff (EVSS), in the laundry room, clothing cart rack with cover (approximately 5 inches slit hole on right side of the cart cover) was one step away from the dirty hamper with overflowing of dirty and soiled residents' personal clothing, two dirty and soiled hampers lids were completely open, a clean white shirt and black long sleeves were hanging at the corner of the dryer, a basket containing personal blankets and residents' clothing were stored on the floor, a bread and a cup of coffee was on the top of the dryer. The EVSS stated I eat here, eat while working. The EVSS stated the clean clothing cart was not empty when he opened the cart. The EVSS stated the clothing cart contained clean shirts and female tops in a hanger and multiple socks. The EVSS stated a basket on the floor containing a clean resident's blanket and clothing. The EVSS stated he should not eat inside the laundry room and dirty hampers should remain closed and not overflowing which could cause cross contamination and infection to himself and residents. The EVSS stated the clean clothing rack should be emptied before doing the laundry to ensure clean items were not contaminated by the dirty items. The EVSS stated he did not have current training for environmental services. The EVSS stated the last environmental services training he received was years ago and stated, can't remember the year. During an interview on 2/10/26 at 9:35 a.m. with the EVS Manger (EVSM), the EVSM stated it was his expectations for EVS staff not to eat inside the laundry room- no drinks and food, dirty hampers must be kept close and not overflowing, keeping the clean clothing rack covered and away from the dirty hamper, a basket of clean personal clothing and blankets should not be stored on the floor and clean clothing cart should be emptied out prior to start washing the dirty and soiled clothing to prevent cross contamination and infection. The EVSM stated a bigger room was needed to keep the dirty hampers away from the clean cart or have a separate room for clean dirty items. During an interview on 2/10/26 at 9:44 a.m. with the IP, the IP stated it was disheartening to see our staff performing laundry services tasks not adhering to the infection control standards of practice. The IP (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated it was not acceptable to eat inside the laundry room while working. The IP stated it was her expectation for the EVS staff to follow the P&P for infection control while doing laundry to prevent cross contamination. The IP stated there will be a high risk of cross contamination when dirty hamper overflows and not keep it closed. The IP stated the facility will do thorough retraining for all EVS staff and stated, Historically they never had their annual training and competency done. The IP stated our goal for this year is to provide training for EVS staff. During an interview on 2/10/26 at 2:46 p.m. with the DON, the DON stated it was disappointing that EVS staff are not following infection control standards of practice. The DON stated the risk of cross-contamination was high, if there are Clostridium Difficile (C. Diff. - a bacterium causing severe, often antibiotic-associated diarrhea, fever, and abdominal pain, primarily affecting people 65 or older or those with weakened immune systems) cases, spores can be transmitted from the staff to the residents. The DON stated the facility was providing laundry services for all the residents. During a review of facility's policy and procedures (P&P) titled Laundry and Bedding, Soiled, dated 9/2022, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Handling - 1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting) . Storage - Clean linen is stored separately, away from soiled linens, at all times. 3. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated space with a closing door are used to reduce the risk of accidental contamination. Onsite Laundry Processing - 2. The receiving area for contaminated textiles is clearly separated from clean laundry areas. Workflow is designed to prevent cross-contamination. Personal Clothing - 1. Personal clothing that becomes soiled with blood or body fluids is covered (e.g., with a gown) or removed and immediate laundered before leaving the work area. During a review of facility's P&P titled, Standard Precautions, dated 10/2018, the P&P indicated, Standard Precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions are presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. 2. Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations. 7. A. Linen soiled with blood, body fluids, secretions, excretions are handled and processed in a manner that prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments. 2. During a concurrent interview and record review on 2/6/26 at 11:14 a.m. with the IP, the IPCP binder was reviewed. The IP indicated the IPCP was last reviewed by the infection control committee on 3/2023, signed by department managers on 3/8/26, signed by medical director on 3/16/23, signed by chief executive officer on 6/29/23, and adopted by the board of directors on 6/28/23. The IP stated the facility's IPCP should be reviewed every year to ensure infection control standards of practice is being achieved and followed according to the facility's P&P and regulation to prevent the risk of infection and outbreaks. The IP stated they were currently reviewing the IPCP. During an interview on 2/6/26 at 4:22 p.m. with the DON, the DON stated the facility's IPCP should be reviewed by the Committee every year and as needed to ensure we are complying with the regulation and infection control stand of practice to prevent cross contamination and infection. During a review of professional reference retrieved from https://www.ahcancal.org/Quality/Clinical-Practice/Documents/Hot%20Topic_Annual%20Review%20Process titled, Annual Review Process for the Infection Prevention and Control Program (IPCP), the professional reference indicated, Completing an annual evaluation of the infection prevention and control program (IPCP) is a requirement for long-term care facilities. This systematic annual review of key aspects of the facility's IPCP is an expectation of CMS, public health, accreditation organizations and infection prevention and control standards for long-term care and acute care settings. By conducting an annual review, the Infection Preventionist (IP) can identify gaps in the Infection (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Prevention and Control Program (IPCP) more easily, establish action plans, and implement Interventions to drive improvement and reduce infection control risks, utilizing Quality Assurance/Performance Improvement (QAPI) program principles in LTC.		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on observation, interview, and record review, the facility failed to implement and maintain an effective training program for all staff when an Environmental Services Staff did not receive training for proper handling, storing, and processing of residents' personal clothing for more than a year. These failures to follow proper practices in handling, storing, and processing of residents' personal clothing had the potential to result in an increased risk of cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and developing an avoidable facility acquired infection (the invasion of the body by harmful microorganisms). During a concurrent observation and interview on 2/6/26 at 8:51 a.m. with Licensed Vocational Nurse (LVN) 2, in the laundry room, the dirty hamper was widely open with overflowing of bagged soiled and dirty residents' personal clothing, and a container of cookies was on the top of the counter. LVN 2 stated the dirty hamper should not be overflowing and should remain closed to prevent cross contamination from dirty to clean items. LVN 2 stated clean and dirty clothing was stored in the same room. LVN 2 stated food should not be stored in the laundry room. During an interview on 2/6/26 at 11:14 a.m. with the Infection Preventionist (IP), the IP stated Environmental Services (EVS) was responsible in facilitating laundry services for all residents' personal clothing. The IP stated it was her expectation to keep the lids of dirty hampers always close when not being accessed by staff. The IP stated the dirty hampers should not be overflowing with dirty clothing and bagged soiled clothing to prevent cross contamination. The IP stated food should not be stored in the laundry room to prevent potential risk of cross-contamination. During an interview on 2/6/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated food was not allowed inside the laundry room to prevent cross contamination. During a concurrent observation and interview on 2/10/26 at 9:13 a.m. with Environmental Services Staff (EVSS), in the laundry room, clothing cart rack with cover (approximately 5 inches slit hole on right side of the cart cover) was one step away from the dirty hamper with overflowing of dirty and soiled residents' personal clothing, two dirty and soiled hampers lids were completely open, a clean white shirt and black long sleeves were hanging at the corner of the dryer, a basket containing personal blankets and residents' clothing were stored on the floor, a bread and a cup of coffee was on the top of the dryer. The EVSS stated I eat here, eat while working. The EVSS stated the clean clothing cart was not empty when he opened the cart. The EVSS stated the clothing cart contained a clean shirts and female tops in a hanger and multiple socks. The EVSS stated a basket on the floor containing a clean resident's blanket and clothing. The EVSS stated he should not eat inside the laundry room and dirty hampers should remain closed and not overflowing which could cause cross contamination and infection to residents. The EVSS stated the clean clothing rack should be emptied before doing the laundry to ensure clean items were not contaminated by the dirty items. The EVSS stated he did not have current training for environmental services. The EVSS stated the last environmental services training he received was years ago and stated, can't remember the year. more than a year. During an interview on 2/10/26 at 9:35 a.m. with the EVS Manger (EVSM), the EVSM stated it was his expectations for EVS staff not to eat inside the laundry room- no drinks and food, dirty hampers must be kept close and not overflowing, keeping the clean clothing rack covered and away from the dirty hamper, a basket of clean personal clothing and blankets should not be stored on the floor and clean clothing cart should be emptied out prior to start washing the dirty and soiled clothing to prevent cross contamination and infection. The EVSM stated a bigger room was needed to keep the dirty hampers away from the clean cart or have a separate room for clean dirty items. The EVSM stated he will provide training for his staff to ensure they will receive necessary training needed to properly perform their job duties and responsibilities. During an interview on 2/10/26 at 9:44 a.m. with the IP, the IP stated it was disheartening to see our staff performing laundry services tasks not adhering to the infection control standards of practice. The IP (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated it was not acceptable to eat inside the laundry room while working. The IP stated it was her expectation for the EVS staff to follow the P&P for infection control while doing laundry to prevent cross contamination. The IP stated there will be a high risk of cross contamination when dirty hamper overflows and not keep it closed. The IP stated she and EVSM will do thorough retraining for all EVS staff and stated, Historically they never had their annual training and competency done. The IP stated our goal for this year is to provide training for EVS staff. During a review of facility's policy and procedures (P&P) titled Laundry and Bedding, Soiled, dated 9/2022, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Handling - 1. All used laundry is handled as potentially contaminated using standard precautions (e.g., gloves and gowns when sorting) . Storage - Clean linen is stored separately, away from soiled linens, at all times. 3. Clean linen is kept separate from contaminated linen. The use of separate rooms, closets, or other designated space with a closing door are used to reduce the risk of accidental contamination. Onsite Laundry Processing - 2. The receiving area for contaminated textiles is clearly separated from clean laundry areas. Workflow is designed to prevent cross-contamination. Personal Clothing - 1. Personal clothing that becomes soiled with blood or body fluids is covered (e.g., with a gown) or removed and immediately laundered before leaving the work area. During a review of EVVS class classification titled Custodian, dated 2/25/25, indicated, Under general supervision, Custodian I employees perform a variety of cleaning tasks. TYPICAL ACTIVITIES: Washes SNF residents' laundry as required when a launderer is unavailable. KNOWLEDGE AND ABILITIES: Incumbents must possess knowledge of relevant District and Housekeeping Department policies and procedures. Possesses the ability to use cleaning materials and operate Housekeeping Department equipment with skill and efficiency. Complies with infection control policies, quality assurance, and confidentiality standards and policies. During a review of EVSM job description, revised on 7/30/21, the job description indicated, .V. Major Duties and Responsibilities 1.8 Discusses defective or unacceptable goods or services with inspection of quality control personnel, users, . and others to determine source of trouble and takes corrective action. 2. Follow District and Departmental policies and procedures. VI. Prevention/Education/Surveillance Responsibilities: Completes Annual Employee Safety Review and Test. Annual Skills Review. Compliance and Quality Improvements. Personnel Policies and Procedures.		

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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** Based on observation, interview, and record review, the facility failed to follow policy and procedures (P&P) for Medication Administration to meet professional standards of quality for two of six sampled residents (Resident 3 and 13) when Licensed Vocational Nurse (LVN) 1 did not use two resident identifiers prior to administering medications and did not explain the name and indication of the medications being administered for Resident 13 and Resident 3. These failures placed Resident 13 and Resident 3 at risk for medication errors, unrecognized adverse drug reactions, and decrease compliance. During an observation on 2/5/26 at 1:17 p.m. with LVN1, outside Resident 13's room, LVN 1 parked the medication cart, knocked on Resident 13's door and informed Resident 13 she will administer her afternoon medications. LVN 1 started preparing Resident 13's 2:00 p.m. medications on top of the medication cart. LVN 1 placed two tablets of Vaccinium macrocarpon (dietary supplement used to support urinary tract health), one tablet of Calcium Carbonate Cholecalciferol (used to prevent or treat low blood calcium levels, and one tablet of Glucosamine Complex (used to support joint [the anatomical point where two or more bones connect], cartilage [protective tissue at the ends of the bones], and mobility, often for osteoarthritis [occurs when the flexible, cartilage wears down causing pain and stiffness] in medication cup. LVN 1 went to Resident 13's room holding a cup of medications and a cup of water. LVN 1 asked Resident 13 to state her name (Resident 13 stated her full name) and LVN 1 stated, two cranberries, GNP and calcium. Resident 13 took the cup containing her medications, and stated, I don't know what they are. Resident 13 swallowed all the medications in the cup. Resident 13 had no identification bracelet. LVN 1 did not explain the type and indication of the medications administered to Resident 13. During a record review of Resident 13'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 10/29/25, the AR indicated Resident 13 was admitted to the facility on [DATE] with primary diagnosis of Polyosteoarthritis (means five or more of your joints have arthritis at the same time). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/25/26, the MDS section C indicated Resident 13 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 13 was cognitively intact. During an observation on 2/5/26 at 1:22 p.m. with LVN 1, at the hallway, LVN 1 approached Resident 3 and received approval from Resident 3 to administer her medication at the hallway. LVN 1 prepared Resident 3's 2:00 p.m. medication on the top of the medication cart. LVN 1 placed one tablet of Pramipexole Dihydrochloride (used to treat the symptoms of Parkinson's disease [shaking, stiffness, slow movement]) in a medication cup. LVN 1 asked Resident 3 to state her name (Resident 3 stated her full name) and did not have an identification bracelet. LVN 1 handed the medication cup to Resident 3 and stated, one tablet of Mirapex. LVN 1 administered the medication with a cup of water without explaining the type and indication of the medications administered to Resident 3. During a review of Resident 3's Electronic Medication Administration Record (EMAR- an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 2/2026 was reviewed. The EMAR indicated, .Pramipexole Dihydrochloride Give 1 tablet by mouth three times a day related to Parkinsonism (is a general term for movement disorders with symptoms like tremor, stiffness, and slow movement) .Start Date 2/6/25. During a record review of Resident 13's AR dated 3/18/25, the AR indicated Resident 3 was admitted to the facility on [DATE] with primary diagnosis Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) with Dyskinesia (s a movement disorder characterized by (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	involuntary, erratic, and uncontrollable body movements).During a review of Resident 3's MDS dated 12/9/25, the MDS section C indicated Resident 3 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 suggested Resident 3 was cognitively intact.During an interview on 2/5/26 at 11:03 a.m. with LVN 1, LVN stated and validated that she used one resident identifier by asking Residents 13 and 3 to state their name and informed them the name of their medications. LVN stated she did not explain the type and indication of the medications administered to Resident 13. LVN 1 stated the facility was not using an identification bracelet for the residents. LVN stated she should follow the facility's P&P to use two resident identifiers to properly identify the resident before administering medication to prevent medication errors. LVN 1 stated it was important to explain the type and indication of medications being administered to the residents to be well informed and understand what medications they are receiving and to prevent potential negative outcomes including side effects of the medications. During an interview on 2/6/26 at 4:22 p.m. with Director of Nursing (DON), the DON stated her expectation for the licensed nurses is to follow the P&P for medication administration. The DON stated using one resident identifier had the potential risk of administering the medication to the wrong resident resulting in medication error. The DON stated that using two resident identifiers is important to identify the right resident and administer the right medication to prevent medication errors. The DON stated explaining medication to all residents is required before medication administration, for the residents to understand what medications they are getting and allow opportunities for decision making. During a review of facility's P&P, titled Medication Administration General Guidelines, dated 1/23, the P&P indicated, .Medication Administration: 10. Residents are identified before medication is administered using at least two resident identifiers. Methods of identification may include a. Check identification band b. Check photograph attach to medical record c. Verify resident identification with other nursing care center personnel; Note: the resident's room number or physical location is not used as an identifier.13. Explain to resident the type of medication being administered and the procedure.		

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NAME OF PROVIDER OR SUPPLIER John C. Fremont Healthcare District Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 5189 Hospital Road Mariposa, CA 95338	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews and record reviews, the facility failed to ensure food stored in the resident refrigerator was consistently monitored and maintained to prevent expired items from being available to residents. This failure affected all 15 residents, as they all received food provided by the facility, and placed them at risk for foodborne illness. Findings: During an observation on 2/4/26 at 1:28p.m. of the resident refrigerator located at the nurses' station, two cartons of milk were observed with use by dates of 2/3/26. During an interview on 2/5/26 at 11:42a.m. with the Certified Dietary Manager (CDM), the CDM stated the process for stocking the resident refrigerator involved skilled nursing facility (SNF) staff completing a request form for needed items. The CDM stated kitchen staff prepared the requested items and delivered them to the SNF unit. The CDM stated the SNF staff were responsible for maintaining the refrigerator and its contents, including monitoring and documenting refrigerator temperatures. The CDM stated once the food items were delivered from the kitchen to the SNF unit, the responsibility for those food items transferred to the SNF staff. During an interview on 2/6/26 at 8:49a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated the night shift CNA was responsible for maintaining the resident refrigerator. CNA 1 stated the resident refrigerator was checked nightly to ensure that no food items were expired and it was deep cleaned on Sundays. CNA 1 stated there should not have been any expired items in the refrigerator. CNA 1 stated if a resident consumed expired food, it could cause illness. During an interview on 2/6/26 at 8:53 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated there should not be any expired items in the resident refrigerator. LVN 2 stated consumption of expired food could increase the risk of foodborne illness (a sickness that happens when consuming contaminated food) for the residents. During an interview on 2/6/26 at 11:42a.m. with the Infection Preventionist (IP), the IP stated she agreed with the process described by the CDM regarding how the resident refrigerator was stocked and maintained. The IP stated the resident refrigerator was to be cleaned routinely and expiration dates were to be checked to ensure no outdated food items were present. The IP stated the presence of expired food items posed a risk to residents, as consumption could result in foodborne illness. During an interview on 2/10/26 at 10:10a.m. with the Director of Nursing (DON), the DON stated the expectation was there were not out of date items in the resident refrigerator. The DON stated it was part of the night shift CNA's responsibility to clean the refrigerator and check expiration dates. The DON stated if a resident consumed expired food, it could result in food poisoning and negatively impact the resident's health. During a review of the facilities policy and procedure (P&P) titled, Food Receiving and Storage, dated 11/2022, the P&P indicated, Refrigerated food are labeled, dated and monitored so they are used by their use-by date, frozen or discarded.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to notify the Office of the State Long-Term Care Ombudsman (an independent official who assist residents in long-term care facilities with issues related to day-to-day care, health, safety, and personal preference) of the transfer or discharge for one of one resident sample resident (Resident 2) when Resident 2 was transferred to acute care hospital and discharged from the facility. This failure had the potential for Resident 2 not receiving due process and protection against improper discharge. During a record review of Resident 2'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 10/1/24, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing) chronic atrial fibrillation (an irregular and often very rapid heart rhythm lasting more than a week), chronic kidney disease (a gradual loss of kidney function where the kidneys cannot filter the blood as they should), 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). Resident was discharged on 1/26/26. During an interview on 2/6/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated Resident 2 was transferred to acute hospital due to a significant change in health condition on 1/26/26. The DON stated, she discharged Resident 2 today (2/6/26) and packed all her belongings. The DON stated she failed to notify the Ombudsman regarding Resident 2's transfer and discharge. The DON stated it is in regulation to notify the Long-Term Care Ombudsman for resident transfers and discharges to be aware of where the resident was transferred or discharged to. The DON stated the facility must comply with the regulation to ensure residents are safe. During a review of facility's policy and procedures (P&P) titled, Transfer and Discharge Notices, dated 3/2025, the P&P indicated Residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Ombudsman. Notice of Transfer or Discharge (Emergency) - 1. When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected. 2. Notice of transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements) . Notice of Discharge after Transfer - 1. If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). 3. The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman. 4. Notice to the Office of the State LTC Ombudsman will occur at the same time as the notice of discharge is provided to the resident and resident representative .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 one of five sampled resident (Resident 1) when Resident 1's nutrition care plan for significant weight gain was not developed. This failure resulted in Resident 1 not being assessed for significant weight gain by qualified staff and had the potential for Resident 1 to experience unrecognized negative outcomes including fluid retention, decline in oral intake, worsening of shortness of breath, and decrease in functional mobility. During a concurrent observation and interview on 2/5/26 at 12:15 p.m. with Resident 1, in the dining room, Resident 1 was sitting in a reclining chair, lunch tray was served. Resident 1 was looking at her lunch tray, sitting back on her recliner chair, and was looking around the environment. Resident 1 was not eating her lunch meal. Resident 1 was alert and able to state her name, wearing glasses and well groomed. Resident 1 had difficulty in hearing during conversation and no hearing aid presence on both ears. Resident 1 with ongoing oxygen at two liters per minute (lpm- oxygen flow rate) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 1's bilateral lower extremities were enlarged with pants tightly fitted. During an observation on 2/6/26 at 8:13 a.m. with Resident 1, in the dining room, Resident 1 was sitting in reclining chair with breakfast tray in front of her. Resident 1 was not eating and repetitively making a sound like she was singing. Resident 1's pant was tight from thigh to the calves. During an observation on 2/6/26 at 8:22 a.m. with Resident 1, in the dining room, Resident 1 took one bite of French toast. Resident 1 kept scooping the oatmeal in a bowl and not eating it. Resident 1 pushed the table containing the breakfast tray away from her, sat back and started singing. During a concurrent observation and interview on 2/6/26 at 8:28 a.m. with CNA 1, in the dining room, CNA 1 turned towards Resident 1, provided cueing and encouraged Resident 1 to eat. CNA 1 stated Resident 1 had not eaten well and easily gets distracted during meals. CNA 1 stated Resident 1 refused to eat at the dining table with nursing staff. During an interview on 2/6/26 at 9:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 1 had a decrease in oral intake, and a nutritional supplement was started. LVN 2 stated Resident 1 started gaining weight when she was taking the nutritional supplement. LVN 2 stated Resident 1's bilateral lower extremities had been big. LVN 2 stated Resident 1 had no edema and stated, probably lymphedema (a chronic condition characterized by swelling, usually in the arms or legs, caused by a buildup of protein-rich lymph fluid due to a damaged or blocked lymphatic system)? LVN 2 stated she did not assess Resident 1 for edema. During an interview on 2/6/26 at 9:49 a.m. with CNA 1, CNA 1 stated Resident 1 had a decrease in appetite, and all her weight was on her calves and thighs. During an observation on 2/6/26 at 12:25 a.m. with Resident 1, in the dining room, Resident 1 had the lunch tray meal in front of her, Resident was not eating and was looking around her surroundings. During a concurrent interview and record review on 2/6/26 at 3:52 p.m. with LVN 1, Resident 1's weights were reviewed. The weights indicated, 12/1/25 148.5 lbs. (pounds -a unit of weight and mass) +5% (more than five percent) change in 30 days compared to 11/1/2025 of 141 lbs. 2/1/26 151 lbs. LVN 1 stated Resident 1 had a significant weight change in 30 days and had a gradual increase in weight. LVN 1 stated Resident 1 had a decrease in appetite and oral intake had decreased. LVN 1 stated Resident 1 had been gaining weight with decreased oral intake. During a concurrent interview and record review on 2/10/26 at 10:58 a.m. with LVN 1, Resident 1's progress notes titled Weight Note, dated 12/1/25 and weights from 11/1/25 to 2/1/26 were reviewed. The progress notes indicated, .Resident had monthly weight completed 12/1/25. Current weight 148.5 Increase of (5.5 lbs., 3.8%) . The weights indicated, 2/1/2026 151.0 lbs., 1/31/2026 150 lbs., 1/1/2026 150 lbs., 12/30/25 148 lbs., 12/23 /25 149 lbs., 12/9/25 146.5 lbs., 12/1/25 148.5 lbs., 11/29/25 143 lbs., 11/1/25 141.1 lbs. LVN 1 stated she was the nurse who notified the physician and the responsible party for Resident 1's significant (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weight gain of more than five pounds on 12/1/25. LVN 1 stated she notified the physician and responsible party based on Resident 1's weight and stated, based on numbers. LVN 1 stated she did not assess Resident 1 related to significant weight gain and continued gradual weight gain. LVN 1 stated Resident 1 sleeps a lot, and she was guessing that causing the weight gain. LVN 1 stated nursing assessment was very important, and stated, to catch whatever is going on before it gets worse. LVN 1 stated Resident 1 should be assessed from head to toe to make sure she was not getting fluids built-up which could worsen her breathing. LVN 1 stated she should assess Resident 1 to rule out the cause of significant weight gain. LVN 1 stated there was no weekly weight meeting and no formal discussion regarding significant weight changes. During a concurrent interview and record review on 2/10/26 at 11:25 a.m. with the Registered Dietitian, Resident 1's weights and laboratory values were reviewed. The RD indicated Resident had a 13 lbs. weight gain in 6 months, and stated, definitely a trend up. The RD stated Resident 1 had been having a gradual weight gain. The RD indicated Resident's recent albumin level (representing a vital protein produced by the liver to maintain fluid balance and transport substances) was 2.8 and stated, definitely low. The RD stated Resident 1's diet was regular moist and minced, half portion, and she consumed about 50%. The RD stated Resident 1 does not eat much but had tendency to drink more of her strawberry milk. The RD stated Resident 1 had history of edema (swelling caused by excess fluid trapped in the body's tissues, commonly occurring in the legs, feet, and ankles). The RD stated based on his assessment Resident 1's weight gain was fat weight. The RD stated he should complete a nutritional assessment when Resident 1 triggered a significant weight gain. The RD stated it was the facility's protocol to place residents with significant gain or loss on weekly weights to closely monitor their weights and to rule out the cause of significant weight changes. The RD stated Resident 1 significant weight gain met the criteria of being on weekly weights. The RD stated she was not on weekly weights and started on weekly weights today (2/10/26). The RD stated Resident 1's significant weight gain should be care planned to ensure necessary interventions were in place. The RD stated care plan for significant weight changes should be developed and updated to ensure residents are receiving appropriate interventions to prevent significant weight changes. The RD stated the facility does not have a weekly weight meeting to formally discuss significant weight changes. The RD stated the facility is creating a Nutrition Committee to conduct a weekly nutrition meeting to formally discuss residents with significant weight changes to properly address significant weight changes including assessments, additional interventions, and monitoring. During a concurrent interview and record review on 2/10/26 at 1:07 p.m. with LVN 1, Resident 1's nutrition care plan was reviewed. LVN 1 stated she cannot locate a significant weight gain nutrition care plan. LVN 1 stated Resident 1's nutrition care plan for significant weight gain should be created and implemented to monitor Resident 1's weights weekly for any changes to ensure Resident 1 was not retaining fluids which could worsen her breathing and functional mobility. LVN 1 stated care plan should be person-centered based on residents' assessment and needs. During a concurrent observation and interview on 2/10/26 at 1:45 p.m. with Minimum Data Set Coordinator Nurse (MDSCN), in the dining room, Resident 1's lower extremities were assessed. Resident 1's pants and socks were tight. Resident 1's skin above both ankles were marks of indention from the socks. Resident 1's legs were smooth and enlarged. MDSCN stated he was a Registered Nurse (RN). MDSCN stated Resident 1's socks were tight and there was slight indention of the skin above both ankles. The MDSCN stated Resident 1's legs were not red with normal temperature. The MDSCN stated Resident 1's legs were large and no edema and stated, seem edematous. it's not edema. The MDSCN stated the physician needed to assess and diagnose. During a concurrent interview and record review on 2/10/26 at 2:00 p.m. with the MDSCN, Resident 1's care plan report titled Nutrition, dated 10/8/24 was reviewed. The Nutrition care plan indicated, At risk for impaired nutrition related to diagnosis of anemia, .dementia, .depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life). Goal: Resident will have no significant weight loss or gain through next review. Interventions: Monitor for fluid loss from (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mouth, drooling, coughing, choking, and pain in swallowing. Monitor weight monthly, weekly or as ordered. The MDSCN stated the nutrition care plan did not address Resident 1's significant weight gain and care plan goals should be measurable. The MDSCN stated Resident 1's nutrition care plan interventions did not include interventions related to Resident 1's significant weight gain. The MDSCN stated Resident 1's nutrition care plan interventions focused on interventions to prevent weight loss related to poor oral intake. The MDSCN stated Resident 1 had episodes of drooling, difficulty eating and chewing, and trouble swallowing. The MDSCN stated Resident 1 does not like the nutritional supplement and likes snacks and candies. The MDSCN stated Resident 1's care plan should be person-centered and stated, it's generic care plan. The MDSCN stated care plan for significant weight gain should be developed and implemented for Resident 1 to receive necessary care and treatment. The MDSCN stated nutrition care plan should be updated to reflect Resident 1's current intervention to prevent significant weight changes including weight gain. The MDSCN stated that a comprehensive person-centered care plan was an important communication tool for nursing staff. During an interview on 2/10/26 at 2:41 p.m. with the Director of Nursing (DON), the DON stated Resident 1 was not assessed for significant weight gain. The DON stated Resident 1 had a decrease in oral intake and had a significant weight gain. The DON stated Resident 1 had no edema and she always had a bigger extremity particularly on bilateral lower extremities. The DON stated it was her expectation for licensed nurses to follow the facility's policy and procedures (P&P) for weights in which five percent of weight gain was considered significant and should be addressed to provide necessary intervention to prevent significant weight changes. The DON stated conducting residents' assessment is important to identify potential cause of significant weight changes. The DON stated the facility will create a weight nutrition committee to conduct a weekly nutrition meeting to discuss residents' significant and gradual weight changes to properly assess, develop a person-centered care plan to address resident's needs, and monitor resident's response to intervention. The DON stated care plan should be reviewed and updated to identify interventions might not be effective to achieve resident's goals. During a review of Resident 1'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 10/1/24, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), Heart Failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), Anemia (disease that occurs when the body doesn't have enough red blood cells to carry oxygen), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/25/25, the MDS section C indicated Resident 1's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 1's BIMS Summary Score was blank. During a review of facility's P&P titled, Care Plans, Comprehensive Person Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 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 the resident's highest practicable physical, mental, and psychosocial well-being, including: d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions; 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. When (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. During a review of facility's P&P titled, Nutrition Assessment, dated 10/2027, the P&P indicated, . 3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: a. Nursing. c. Physicians and Practitioners. d. Dietitian. 7. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address minimize to the extent possible the resident's risk for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. 8. Individualized care plans shall address to the extent possible: a. the identified causes of impaired nutrition; b. the resident's personal preferences; c. goals and benchmarks for improvement; and d. time frames and parameters for monitoring and reassessment. During a review of facility's P&P titled, Weight Assessment and Intervention, dated 10/2017, the P&P indicated, Resident weights are monitored for undesirable or unintended weight loss or gain. Weight Assessment 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. If the weight is verified, nursing will immediately notify the dietitian in writing. 4. Unless notified of significant weight changes, the dietitian will review the unit weight record monthly to follow individual weight trends over time. During a review of Nursing World.org Professional Reference titled, The American Nurses Association- Nursing: Scope and Standards of Practice, Third Edition, dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, . The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making. Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation. During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to review and revise a comprehensive person-centered care plan to reflect assessments and interventions to address a significant weight changes for one of four sampled residents (Resident 1) when Resident 1's nutritional care plan was not revised to reflect Resident's 1's significant weight gain of more than five percent in 30 days and continued gradual weight gain. These failures had the potential for Resident 1 not to receive the necessary care and services and put Resident 1 at an increased risk of unintended weight gain. During a concurrent observation and interview on 2/5/26 at 12:15 p.m. with Resident 1, in the dining room, Resident 1 was sitting in a reclining chair, lunch tray was served. Resident 1 was looking at her lunch tray, sitting back on her recliner chair, and was looking around the environment. Resident 1 was not eating her lunch meal. Resident 1 was alert and able to state her name, wearing glasses and well groomed. Resident 1 had difficulty in hearing during conversation and no hearing aid presence on both ears. Resident 1 with ongoing oxygen at two liters per minute (lpm- oxygen flow rate) via nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 1's bilateral lower extremities were enlarged with pants tightly fitted. During an observation on 2/6/26 at 8:13 a.m. with Resident 1, in the dining room, Resident 1 was sitting in reclining chair with breakfast tray in front of her. Resident 1 was not eating and repetitively making a sound like she was singing. Resident 1's pant was tight from thigh to the calves. During an interview on 2/6/26 at 9:02 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 1 had a decrease in oral intake, and a nutritional supplement was started. LVN 2 stated Resident 1 started gaining weight when she was taking the nutritional supplement. LVN 2 stated Resident 1's bilateral lower extremities had been big. LVN 2 stated Resident 1 had no edema and stated, probably lymphedema (a chronic condition characterized by swelling, usually in the arms or legs, caused by a buildup of protein-rich lymph fluid due to a damaged or blocked lymphatic system)? LVN 2 stated she did not assess Resident 1 for edema. During an interview on 2/6/26 at 9:49 a.m. with CNA 1, CNA 1 stated Resident 1 had a decrease in appetite, and all her weight was on her calves and thighs. During an observation on 2/6/26 at 12:25 a.m. with Resident 1, in the dining room, Resident 1 had a lunch tray meal in front of her, Resident was not eating and was looking around her surroundings. During a concurrent interview and record review on 2/6/26 at 3:52 p.m. with LVN 1, Resident 1's weights were reviewed. The weights indicated, 12/1/25 148.5 lbs. (pounds -a unit of weight and mass) +5% (more than five percent) change in 30 days compared to 11/1/2025 of 141 lbs. 2/1/26 151 lbs. LVN 1 stated Resident 1 had a significant weight gain in 30 days and had a gradual increase in weight. LVN 1 stated Resident 1 had a decrease in appetite and oral intake had decreased. LVN 1 stated Resident 1 had been gaining weight with decreased oral intake. During a concurrent interview and record review on 2/10/26 at 10:58 a.m. with LVN 1, Resident 1's progress notes titled Weight Note, dated 12/1/25 and weights from 11/1/25 to 2/1/26 were reviewed. The progress notes indicated, .Resident had monthly weight completed 12/1/225. Current weight 148.5 Increase of (5.5 lbs., 3.8%) . The weights indicated, 2/1/2026 151.0 lbs., 1/31/2026 150 lbs., 1/1/2026 150 lbs., 12/30/25 148 lbs., 12/23 /25 149 lbs., 12/9/25 146.5 lbs., 12/1/25 148.5 lbs., 11/29/25 143 lbs., 11/1/25 141.1 lbs. LVN 1 stated she was the nurse who notified the physician and the responsible party for Resident 1's significant weight gain of more than five pounds on 12/1/25. LVN 1 stated she notified the physician and responsible party based on Resident 1's weight and stated, based on numbers. LVN 1 stated she did not assess Resident 1 related to significant weight gain and continued gradual weight gain. LVN 1 stated Resident 1 sleeps a lot, and she was guessing that causing the weight gain. LVN 1 stated nursing assessment was very important, and stated, to catch whatever is going on before it gets worse. LVN 1 stated Resident 1 should be assessed from head to toe to make sure she was not getting fluids (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER John C. Fremont Healthcare District Dp/Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 5189 Hospital Road Mariposa, CA 95338	
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	built-up which could worsen her breathing. During a concurrent interview and record review on 2/10/26 at 11:25 a.m. with the Registered Dietitian, Resident 1's weights and laboratory values were reviewed. The RD indicated Resident had a 13 lbs. weight gain in 6 months, and stated, definitely a trend up. The RD stated Resident 1 had been having a gradual weight gain. The RD indicated Resident's recent albumin level (representing a vital protein produced by the liver to maintain fluid balance and transport substances) was 2.8 and stated, definitely low. The RD stated Resident 1's diet was regular moist and minced, half portion, and she consumed about 50%. The RD stated Resident 1 does not eat much but had tendency to drink more of her strawberry milk. The RD stated Resident 1 had history of edema (swelling caused by excess fluid trapped in the body's tissues, commonly occurring in the legs, feet, and ankles). The RD stated based on his assessment Resident 1's significant weight gain was fat weight. The RD stated he should complete a nutritional assessment when Resident 1 triggered a significant weight gain. The RD stated it was the facility's protocol to place residents with significant gain or loss on weekly weights to closely monitor their weights and to rule out the cause of significant weight changes. The RD stated Resident 1 significant weight gain met the criteria of being on weekly weights. The RD stated she was not on weekly weights and started on weekly weights today (2/10/26). The RD stated Resident 1's weight gain should be care planned to ensure necessary interventions were in place. The RD stated care plan for significant weight changes should be developed and updated to ensure residents are receiving appropriate interventions to prevent significant weight changes. During a concurrent interview and record review on 2/10/26 at 1:07 p.m. with LVN 1, Resident 1's nutrition care plan was reviewed. LVN 1 stated she cannot locate a significant weight gain nutrition care plan. LVN 1 stated Resident 1's nutrition care plan for significant weight gain should be created and implemented to monitor Resident 1's weights weekly for any changes to ensure Resident 1 was not retaining fluids could worsen her breathing and functional mobility. LVN 1 stated care plan should be person-centered based on residents' assessment and needs. During a concurrent observation and interview on 2/10/26 at 1:45 p.m. with Minimum Data Set Coordinator Nurse (MDSCN), in the dining room, Resident 1's lower extremities were assessed. Resident 1's pants and socks were tight. Resident 1's skin above both ankles were marks of indention from the socks. Resident 1's legs were smooth and enlarged. MDSCN stated he was a Registered Nurse (RN). MDSCN stated Resident 1's socks were tight and there was slight indention of the skin above both ankles. The MDSCN stated Resident 1's legs were not red with normal temperature. The MDSCN stated Resident 1's legs were large and no edema and stated, seem edematous.it's not edema. The MDSCN stated the physician needed to assess and diagnose.During a concurrent interview and record review on 2/10/26 at 2:00 p.m. with the MDSCN, Resident 1's care plan report titled Nutrition, dated 10/8/24 was reviewed. The Nutrition care plan indicated, At risk for impaired nutrition related to diagnosis of anemia, .dementia, .depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life). Goal: Resident will have no significant weight loss or gain through next review. Interventions: Monitor for fluid loss from mouth, drooling, coughing, choking, and pain in swallowing. Monitor weight monthly, weekly or as ordered. The MDSCN stated the nutrition care plan did not address Resident 1's significant weight gain and care plan goals should be measurable. The MDSCN stated Resident 1's nutrition care plan interventions did not include interventions related to Resident 1's significant weight gain. The MDSCN stated Resident 1's care plan should be person-centered and stated, it's generic care plan. The MDSCN stated nutrition care plan should be updated and revised to reflect Resident 1's current intervention to prevent significant weight gain. The MDSCN stated care plan was important because it was a communication tool for nursing staff to ensure residents were getting necessary care and treatment. During an interview on 2/10/26 at 2:41 p.m. with the Director of Nursing (DON), the DON stated Resident 1's was not assessed for significant weight gain. The DON stated Resident 1 had a decrease in oral intake and had a significant weight gain. The DON stated Resident 1 had no edema and she always had a bigger extremity particularly on bilateral lower extremities. The DON stated it (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was her expectation for licensed nurses to follow the facility's policy and procedures (P&P) for weights in which five percent of weight gain was considered significant and should be addressed to provide necessary intervention to prevent significant weight changes. The DON stated conducting residents' assessment is important to identify potential cause of significant weight changes. The DON stated nutrition care plan should be reviewed and updated to identify interventions that might not be effective in achieving resident's goals. During a review of Resident 1'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 10/1/24, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing), Heart Failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), Anemia (disease that occurs when the body doesn't have enough red blood cells to carry oxygen), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/25/25, the MDS section C indicated Resident 1's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 1's BIMS Summary Score was blank.During a review of facility's P&P titled, Care Plans, Comprehensive Person Centered, dated 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 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 the resident's highest practicable physical, mental, and psychosocial well-being, including: d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions;10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.During a review of facility's P&P titled, Nutrition Assessment, dated 10/2027, the P&P indicated, .3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components: a. Nursing. c. Physicians and Practitioners.d. Dietitian. 7. Once current conditions and risk factors for impaired nutrition are assessed and analyzed, individual care plans will be developed that address minimize to the extent possible the resident's risk for nutritional complications. Such interventions will be developed within the context of the resident's prognosis and personal preferences. 8. Individualized care plans shall address to the extent possible: a. the identified causes of impaired nutrition; b. the resident's personal preferences; c. goals and benchmarks for improvement; and d. time frames and parameters for monitoring and reassessment.		

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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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were stored in accordance with the facility's policy and procedures (P&P) Medication Storage to meet professional standards of quality when the medication storage cabinet contained an expired medication with expiration date of 1/2026. This failure had the potential risk for residents to receive expired medications which could result in reduced therapeutic effectiveness, treatment failure and serious health complications. During a concurrent observation and interview on 2/5/25 at 11:03 a.m. with the Licensed Vocational Nurse (LVN) 1, in front of the medication storage cabinet, an unopen bottle of Fish Oil (used to reduce pain, improve morning stiffness and relieve joint tenderness in people with rheumatoid arthritis [a chronic autoimmune disorder where the immune system attacks joint linings (synovium), causing painful inflammation, stiffness, and potential deformity] 1000 mg (milligrams- metric unit of measurement, used for medication dosage and/or amount) with expiration date of 1/2026 was stored inside the medication storage cabinet. LVN 1 validated that the bottle of Fish oil was expired. LVN 1 stated the expired bottle of Fish oil should be destroyed and no expired medication should be stored in the medication storage cabinet to prevent medication error. During an interview on 2/6/26 at 8:38 a.m. with LVN 2, LVN 2 stated storing expired medication in medication cart or in medication storage area can potentially administer to the residents resulting in medication error. LVN 2 stated there should be no expired medications stored in medication cart and medication storage cabinet to prevent the risk of administering expired medication to the residents, and stated, decrease effectiveness. During an interview on 2/6/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated her expectation for the licensed nurses was to follow the P&P for Medication Storage to ensure expired medications are not stored in medication storage cabinet to prevent the potential risk of administering expired medication to the residents. The DON stated there should be no expired medication stored in the medication storage cabinet ready for residents use to prevent medication errors. The DON stated expired medication effectiveness decreased. During a review of facility's P&P titled, Medication Storage, dated 1/23, the P&P indicated, . 14. Outdated . are immediately removed from stock, disposed of according to procedures for medication disposal.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure resident care equipment was maintained in safe and operating condition when the facility's shower chair was not functional to deliver residents' care and activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). This failure placed Resident 13 at risk for falls, skin injuries, equipment malfunction, and serious harm during bathing assistance. During a concurrent observation and interview on 2/4/26 at 1:39 p.m. with Resident 13, in Resident 13's room, Resident 13 was sitting on the left side of her bed watching television. Resident 13 was alert and oriented x 4 (names, time, places, and events/situation), pleasant, and well groomed. Resident 13 stated she had been at the facility for almost four years and had worked at the facility as a housekeeper. Resident 13 stated she was admitted to the facility because she needed assistance with Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when her husband passed away. Resident 13 stated she could not walk, and wheelchair was her primary mode of locomotion. Resident 13 stated she can stand and pivot during transfers from bed to her wheelchair, bedside commode and shower chair. Resident 13 stated she uses her walker during transfers. Resident 13 stated the only concern she had was the broken shower chair. Resident 13 stated the shower chair had been broken since she was admitted four years ago. She stated the shower chair cannot recline and adjust the height that makes it difficult for her to transfer and sit safely in the shower chair. Resident 13 stated she can only sit at the edge of the shower chair and stated, it's a safety concern. Resident 13 stated she is at risk from falling and she can fall while using it. Resident 13 stated she heard that it was expensive to replace the shower chair and stated they should buy a new one. During a record review of Resident 13'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 10/29/25, the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnosis of Polyosteoarthritis (means five or more of your joints have arthritis at the same time), Obesity (a chronic disease defined as having an excessive accumulation of body fat), Reduced Mobility, Cramp and Spasm (painful contractions and tightening of your muscles), and Paresthesia of skin (the burning, tingling, numbness, or pins and needles sensation often described as skin crawling, typically occurring in hands, arms, legs, or feet without an obvious physical cause). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/25/26, the MDS section C indicated Resident 13 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 13 was cognitively intact. The MDS section GG indicated, .Self-Care Section GG e. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair), Resident 13 requires supervision or touching assistance. During a review of Resident 13's care plan report, titled Long term Care plan (LTCP) Falls/Mobility and ADLs, revised on 1/28/26, was reviewed. The falls/mobility care plan indicated, At risk for falls and injury r/t impaired mobility, function, range of motion (ROM) and pain related to polyosteoarthritis. Goal: Resident will have no serious injuries r/t falls through next review. The ADLs care plan indicated, At risk for self-care deficits due to no longer walking and having limited mobility and ROM in bilateral shoulders and right hip related to diagnosis of osteoarthritis (a disease that breaks down one or more joints in the body) with chronic pain to right hip and right shoulder. with bilateral lower extremity swelling. Intervention: Intervention: requires max assist with rolling side to side and sit-lying and independent/set-up assist with lying-sit/transfers by adjusting the height of bed to transfer to/from (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair or bedside commode using walker with set up help. During an interview on 2/5/26 at 11:05 a.m. with Resident 13, Resident 13 stated she had a shower yesterday (2/4/26) and used the broken shower chair. Resident 13 stated she was slow and cautious during transfer. During a concurrent observation and interview on 2/5/26 at 11:44 a.m. with Certified Nurse Assistant (CNA) 1, in resident's shower room, the shower chair cannot be lowered and reclined. The shower chair had no battery. CNA 1 stated the battery got wet during shower and was broken. CNA 1 stated the shower chair was not in good function, cannot recline and adjust the height of the shower chair. CNA 1 stated Resident 13 uses a shower chair and had a shower yesterday (2/4/26). CNA 1 stated Resident 13 is at risk for falls. CNA 1 stated the shower chair should be in good function to be able to adjust the height based on resident's need for safe transfer. CNA 1 stated it was difficult for CNAs to provide care during shower due to malfunctioning of reclining position of the shower chair. During an interview on 2/6/26 at 9:31 a.m. with CNA 3, CNA 3 stated she was familiar with Resident 13. CNA 3 stated Resident 13 was at risk for falls and requires assistance with ADLs. CNA 3 stated Resident 13 uses a shower chair. CNA 3 stated resident's shower chair's height cannot be adjusted. CNA 3 stated the shower chair should be working properly to prevent accidents such as falls. CNA 3 stated Resident 13 can stand with staff supervision; the height of shower chair needed to be adjusted according to Resident 13's height for safe transfer. CNA 3 stated a malfunctioning shower chair is a safety concern. During an interview on 2/6/26 at 4:22 p.m. with the Director of Nursing (DON), the DON stated resident's shower chair was not in good working condition. The DON stated the shower chair cannot be adjusted and reclined and remained in one position. The DON stated malfunctioning of shower chair interferes with resident's care. The DON stated the shower chair should be maintained in good function for the safety of residents and staff. During a concurrent observation and interview with the Senior Director of Facility Operations (SDFO), in the resident's shower room, the shower chair had no battery. The SDFO stated the shower chair needed a battery to properly operate. The SDFO stated the shower chair was not mechanically functioning, and not in good working condition. The SDFO stated he was not aware of shower chair being malfunctioned and he needed to coordinate with the Maintenance Manager. The SDFO stated that a malfunctioned shower chair was a safety risk. During a review of facility's policy and procedures (P&P) titled, Maintenance Service, dated 12/2009, the P&P indicated, Maintenance Service shall be provided to all areas of the building, grounds, and equipment. 3. The maintenance director is responsible for developing and maintaining of schedule maintenance service to assure that the .equipment are maintained in a safe and operable manner. 5. Maintenance personnel shall follow the manufacturer's recommended maintenance schedule. During a review of facility's P&P titled, Hazardous Areas, Devices and Equipment, dated 7/2017, the P&P indicated, All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the event possible. Policy Interpretation and Implementation. 1. As part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the safety committee. Identification of Hazards. 1. A hazard is defined as anything in the environment that as the potential to cause injury or illness. Examples of environmental hazards include, but re not limited to the following: a. Equipment and devices that are left unattended or are malfunctions; b. Devices and equipment that are improperly used or poorly maintained. Assessment Analysis of Hazards. 2. Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous. 3. Resident vulnerability is based on risk factors including the individual resident's functional status, medical condition, cognitive abilities, mood, and health treatments (e.g., medications) .		