STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 meet professional standards of practice for five of 53 of sampled residents (Residents 87, 101, 122, 123 and 124) when:1.Physician (MD) orders for insulin administration lacked parameters for MD notification for low or high blood glucose (a type of sugar in the blood that the body used for energy) levels for two of seven sampled residents (Resident 123 and 124).This failure had the potential to result in delayed MD notification and intervention for abnormal blood glucose levels. 2.Resident 124 experienced significant weight gain and had an SBAR completed on 4/3/26, which required initiation of 72-hour alert charting and ongoing monitoring for fluid overload. Alert charting was not initiated timely, was not completed consistently each shift and lacked communication of edema or related assessments.This failure had the potential to result in delayed identification and treatment of worsening fluid overload or other complications due to lack of consistent clinical monitoring and documentation. 3.Resident 101 had two active physician orders for oxygen (O2- a colorless, odorless and tasteless gas essential for life) dated 3/29/26 and 11/4/25 with the same parameters (defining characteristics that sets the scope for how something is done). This failure had the potential to cause confusion for the Licensed Nurse (LN)s on which of the O2 orders to be administered to Resident 101and could lead to inappropriate O2 administration.4.Resident 87 and Resident 101's O2 flow rate (the quantity of fluid that is passing through a cross-section of a pipe in a specific period of time) was set to 1.5L (liters-a unit of measurement) instead of the ordered 2L. This failure resulted in Resident 87 and Resident 101 not receiving the correct amount of oxygen as ordered by the provider and could have resulted in shortness of breath (SOB) and respiratory distress (difficulty breathing).5. Licensed Vocational Nurse (LVN) 1 placed Resident 122 on BiPap (two-setting non-invasive breathing machine) and current LVN scope of practice (set of rules) indicated LVN's are not allowed to manipulate non-invasive ventilation (adjust a machine that helps with breathing) as of 10/1/25.This failure resulted in LVN 1 practicing outside of her scope of practice.6. Resident 122 had a physician's order to change his nasal cannula (thin plastic tube that delivers oxygen through your nose) tubing every seven days and his nasal cannula tubing was found with a date of 3/30/26 (date tubing was replaced) indicating the nasal cannula should have been replaced on 4/6/2026 but was not. This failure resulted in Resident 122's physician orders not being followed.1. During an interview on 4/7/26 at 10:42a.m. in her room. Resident 123 stated she had type 2 diabetes (a condition where the body did not use glucose properly, causing blood glucose levels to stay high) and reported a recent increase in her blood glucose levels after consuming a strawberry shake.During a review of Resident 123's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/10/26, the AR indicated Resident 123 was admitted to the facility on [DATE] with diagnoses of type two diabetes with ketoacidosis (a serious condition where too much acid built up in the blood because the body could not use glucose for energy). During a review of Resident 123's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/23/26, the MDS indicated Resident 123 had a Brief Interview (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 123 was cognitively intact. During a review of Resident 123's Order Summary Report, dated 4/10/26, the Order Summary Report indicated an active order for insulin lispro administered per sliding scale; however, the order did not include parameters for when to notify the physician (MD) for low or high blood glucose levels. During an interview on 4/7/26 at 11:15a.m. with Resident 124, Resident 124 stated he had diabetes and reported the facility informed him that his blood glucose levels had been in the 400's.During a review of Resident 124's AR, dated 4/10/26, the AR indicated Resident 124 was admitted to the facility on [DATE] with diagnoses of type two diabetes and morbid obesity (a condition where a person had very high weight that could cause serious health problems). During a review of Resident 124's MDS, dated 3/23/26, the MDS indicated Resident 124 had a BIMS score of 15 which suggested Resident 124 was cognitively intact.During a review of Resident 124's Order Summary Report, dated 4/9/26, the Order Summary Report indicated insulin aspart to inject 5 units before meals for diabetes. The order did not include parameters for when to notify the MD for low or high blood glucose levels. During a concurrent interview and review of electronic health records for Residents 123 and 124 on 4/10/26 at 9:04a.m. with the Assistant Director of Nursing (ADON), the ADON stated there should be parameters for MD notification related to abnormal blood glucose levels. The ADON stated the standard was to notify the MD if blood glucose levels were less than 60 mg/dL (a way to measure how much glucose was in the blood, showing how many milligrams [a way to measure a very small amount of something, like medicine] of sugar were in a small amount of blood) or greater than 450 mg/dL and indicated it was the MD's preferred protocol. The ADON further stated the risk of not addressing low or high blood glucose levels was that a resident could go into diabetic shock (when a person's blood glucose got too low or high and their body could not work properly, which could cause confusion, passing out or becoming very sick) or coma (when a persona blood glucose got so high or low that they became unconscious and could not wake up without medical help). A review of the Residents' care plans indicated they did not include parameters for MD notification related to abnormal blood glucose levels. During the interview, the ADON stated there was a document located on each medication cart that provided guidance to nursing staff regarding actions to take for abnormal blood glucose readings. The ADON retrieved the document, which included instructions for low blood glucose levels; however, the document did not include interventions related to high blood glucose levels. During a concurrent interview and review of electronic health records for Resident 123 and 124 on 4/10/26 at 10:53a.m. with Licensed Vocational Nurse (LVN)# ([NAME]), LVN# stated nursing staff were to notify the MD if blood glucose levels were less than 60 mg/dL or greater than 400 mg/dL, and indicated some residents may have parameters of 450 mg/dL, but this was not typical. LVN # stated when a resident had orders for insulin, parameters for physician notification should be included. LVN # further stated MD notification was important to obtain additional treatment orders and to provide direction to nursing staff. During an interview on 4/10/26 at 12:47p.m. with the Director of Nursing (DON), the DON confirmed residents receiving insulin should have defined parameters for MD notification. The DON stated most nurses would recognize the need to notify the MD if the blood glucose levels exceeded the range covered by insulin orders, such as greater than 450 mg/dL. When asked if it was safe practice for a resident receiving insulin to not have MD notification parameters included in the order, the DON stated the parameters were missing from the body of the order. During a review of facilities policy and procedure (P&P) titled, Nursing Care of the Older Adult with Diabetes Mellitus, dated November 2020, the P&P indicated, the provider will order the frequency of glucose monitoring and establish appropriate glycemia targets for individual residents.manage hypoglycemia according to protocols and provider orders.establish provider notification protocols.call provider immediately if resident is hypoglycemic (<70 mg/dL), blood glucose values are <250 mg/dL more than once within a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	24hr period.During a review of facilities policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, dated October 2011, the P&P indicated, report other information in accordance with facility policy and professional standards of practice. During a review of facilities policy and procedure (P&P) titled, Clinical Assessment and Monitoring, undated, the P&P indicated, 5. The licensed nurse will notify the provider promptly for significant abnormal findings2. During an interview on 4/7/26 at 11:15a.m. with Resident 124 in his room, Resident 124 stated he had experienced a recent weight gain. He reported his weight was approximately 200 pounds upon admission and had increased to over 300 pounds. Resident 124 further stated he did not consume large amounts of food and did not eat snacks between meals. During a review of Resident 124's AR, dated 4/10/26, the AR indicated Resident 124 was admitted to the facility on [DATE] with diagnoses of type two diabetes and morbid obesity (a condition where a person had very high weight that could cause serious health problems). During a review of Resident 124's MDS, dated 3/23/26, the MDS indicated Resident 124 had a BIMS score of 15 which suggested Resident 124 was cognitively intact. During a concurrent interview and review of Resident 124's electronic health record on 4/9/26 at 4:15p.m. with the ADON, the ADON stated an Situation Background Assessment Recommendation (SBAR) had been completed for Resident 124 due to a 25 pound weight gain within one month. The ADON stated the MD ordered additional diuretics, including the addition of spironolactone on 4/4/26, and Resident 124 was educated on elevating his feet. The ADON stated Resident 124 had been receiving 40 mg of Lasix upon admission. The ADON stated when a resident triggered for weight gain or loss, the facility completed a change in condition (COC), notified responsible parties (RP) and involved the Registered Dietitian (RD). The ADON confirmed weekly weights were not in place for Resident 124, stated weights were obtained at admission to establish a baseline and had been completed during the first month following admission, and reported the facility did not have a policy addressing ongoing weekly weights. The ADON stated Resident 124 declined outside food as a contributing factor to weight gain. During a concurrent interview and review of Resident 124's electronic health record on 4/10/26 at 8:39 a.m. with the ADON, the ADON stated the expectation for a 25 pound weight gain was to monitor for signs and symptoms of fluid overload and notify the MD if the condition persisted. The ADON stated Resident 124's care plan did not specify a weight monitoring frequency and only indicated weekly times four weeks, monthly and as needed and that weight frequency may be determined during interdisciplinary team (IDT) meetings. The ADON stated if a resident refused weights, staff would attempt multiple times or use different staff. When asked how Resident 124 was monitored without weights, the ADON stated Resident 124 was encouraged and monitored through alert charting for 72 hours following the weight gain, including assessment for fluid overload and edema. A review of the SBAR was completed on 4/3/26 (mid-shift). The ADON stated alert charting should have been initiated on the NOC shift of 4/4/26 and completed every shift for 72 hours; however, it was initiated on 4/6/26 and documented only twice and was not completed consistently each shift. The ADON stated nurses should document alert charting in progress notes and use COC to inform the physician. The ADON stated weight refusals were not documented in the medical record but communicated via a communication sheet and discussed in IDT. When asked how effectiveness of interventions was evaluated without weights, the ADON stated staff assessed for shortness of breath, labored breathing and resolution of edema. During a concurrent interview and review of Resident 124's electronic health record on 4/10/26 at 10:38a.m. with LVN 3, LVN 3 stated Resident 124's weight recorded on 4/2/26 triggered a significant weight gain. LVN 3 stated monitoring included assessing for edema, shortness of breath, meal intake and outside food sources. LVN 3 stated an SBAR completed on 4/3/26 at 3:00p.m. should have initiated 72-hour alert charting beginning the following shift, with documentation every shift (day, evening and night). A review with LVN 3 indicated alert charting for two shifts dated 4/4/26 was entered late on 4/10/26 at 9:36a.m. and 9:38a.m. LVN 3 acknowledged an alert note should have been initiated on the night shift of 4/3/26 and completed each shift thereafter. LVN 3 confirmed the charting was not completed timely or consistently. LVN 3 stated monitoring was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed. The O2 order dated 3/29/26 indicated O2 @ 2L/M via nasal cannula PRN as needed for SOB, the O2 order dated 11/4/25 indicated O2 @3L via nasal cannula PRN as needed for SOB. LVN 1 stated Resident 101 had two O2 orders. LVN 1 stated both orders were PRN orders and both were indicated for SOB. LVN 1 stated the two orders could cause confusion to the LN administering the O2. LVN 1 stated Resident 101 should have one O2 order to ensure it was clear what order should be followed. LVN 1 stated if resident 101 was to have two O2 orders, the parameters for the O2 orders should have been not clearly stated. During a concurrent interview and record review on 4/8/26 at 12:07 p.m. with the Assistant Director of Nursing (ADON), Resident 101's O2 order dated 3/29/26 and 11/4/25 were reviewed. The O2 order dated 3/29/26 indicated O2 @ 2L/M via nasal cannula PRN as needed for SOB, the O2 order dated 11/4/25 indicated O2 @3L via nasal cannula PRN as needed for SOB. The ADON stated two LNs put in the O2 orders. The ADON stated Resident 101 should have only one O2 order. The ADON stated Resident 101 having two O2 orders could lead to miscommunication and Resident 101 could be given a wrong order. During an interview on 4/9/26 at 2:55 p.m. with the Director of Nursing (DON), the DON stated Resident 101's O2 orders should have been put together, and stated as 2-3 L, or there could be two different orders with distinct parameters because the present orders could cause confusion. The DON stated the clarification was important to prevent confusion and for the correct O2 orders could be followed.4. During an observation on 4/7/26 at 10:10 a.m. in Resident 87's room during the initial tour, Resident 87 was in bed with a NC in her nose, connected to a working oxygen concentrator which was set to 1.5 L/M.During a review of Resident 87's AR, dated 4/8/26, The AR indicated, Resident 87 was admitted to the facility on [DATE] from nursing home and had diagnoses that included .chronic obstructive pulmonary disease, personal history of COVID-19.During a review of Resident 87's MDS dated 1/23/26, the MDS section C indicated Resident 87 had a BIMS score of 12 out of 15. The BIMS score indicated Resident 87 had moderate impairment.During a review of Resident 87's OSR, the OSR indicated .O2 @ 2L/M via nasal cannula PRN as needed for SOB or difficulty breathing. order start date 4/25/25. During a concurrent observation, interview and record review on 4/8/26 at 11:59 a.m. with LVN 1 in Resident 87's room, Resident 87 was lying in bed with a NC in her nose, connected to a working oxygen concentrator which was set to 1.5 L/M. LVN 1 validated the O2 was set at 1.5 L. Resident 87's O2 order dated 4/25/25 was reviewed. The O2 order indicated O2 @ 2L/M via nasal cannula PRN as needed for SOB or difficulty breathing. LVN 1 stated the O2 concentrator should not be set at 1.5 L, but at 2L. LVN 1 stated it was the responsibility of the LNs to ensure the O2 was at the right setting. LVN 1 stated Resident 87 was receiving O2 below the physician's order. LVN 1 stated Resident 87 was not receiving enough O2 to ensure O2 saturation was above 90%. LVN 1 stated this could lead to SOB, and respiratory distress.During a review of Resident 101's AR, dated 4/8/26, The AR indicated, Resident 101 was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .chronic obstructive pulmonary disease, Chronic respiratory failure with hypoxia, heart failure.During a review of Resident 101's MDS dated 2/11/26, the MDS section C indicated Resident 101 had a BIMS score of 12 out of 15. The BIMS score indicated Resident 101 had moderate impairment.During a review of Resident 101's OSR, there were 2 OSRs. One OSR indicated .O2 @ 2L/M via nasal cannula PRN as needed for SOB. order start date 3/29/26, and the other OSR indicated O2 @3L via nasal cannula PRN as needed for SOB .order start date 11/4/25.During a concurrent observation, interview and record review on 4/8/26 at 11:27 a.m. with LVN 1 in Resident 101's room, Resident 101 was sitting in her wheelchair with a NC in her nose, connected to a working oxygen concentrator which was set to 1.5 L/M. LVN 1 validated the O2 was set at 1.5 L. Resident 101's O2 order dated 3/29/26 and 11/4/25 were reviewed. The O2 order dated 3/29/26 indicated O2 @ 2L/M via nasal cannula PRN as needed for SOB, the O2 order dated 11/4/25 indicated O2 @3L via nasal cannula PRN as needed for SOB. LVN 1 stated the O2 concentrator should not be set at 1.5 L, but at 2L or 3L. LVN 1 stated it was the responsibility of the LNs to ensure the O2 concentrator was set at the ordered liters. LVN 1 stated Resident 101 was receiving O2 below the physician's order. LVN 1 stated Resident 101 was not receiving enough O2 to ensure O2 saturation (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that time. CNA 6 stated LVN 1 came into Resident 122's room and put the BiPap mask on and turned on the machine. CNA 6 stated while she was in the room, Resident 122 went from the nasal cannula to the BiPap.During a concurrent interview and record review on 4/8/26 at 3:31 p.m. with RT 2, Resident 122's Progress Notes (PN) dated 4/8/26 was reviewed. The PN indicated no documentation of Resident 122 being on BiPap the morning of 4/8/26. RT 2 stated that her shift started at 7:00 a.m. and she had been here all day. RT 2 stated that she did not place Resident 122 on BiPap the morning of 4/8/26. RT 2 stated that she put Resident 122 on BiPap at 2:30 p.m. and documented it in a progress note. RT 2 stated she was unable to find any documentation of Resident 122 being placed on BiPap that morning.During a concurrent interview and record review on 4/10/26 at 9:51 a.m. with the Director of Nursing (DON), a professional reference retrieved from bvnpt.ca.gov titled Changes to Respiratory Care Scope of Practice dated 10/1/25 was reviewed. The professional reference indicated .The Board of Vocational Nursing and Psychiatric Technicians (BVNPT) would like to inform licensees, employers and educators of regulations adopted by the Respiratory Care Board (RCB) impacting the scope of practice licensed vocational nurses (LVNs) going into effect on October 1, 2025. These regulations impact the LVN scope of practice with various changes, as described below. BVNPT licensees, employers and educators are expected to comply with the regulations. LVNs CANNOT perform the following: . Manipulation of an invasive or non-invasive ventilator . DON stated that she was not aware of any scope of practice changes for LVN's. DON stated that all nurses [LVN's and RN's] are trained to administer BiPap at the facility. DON stated it was best practice when a resident was placed on a BiPap, it be documented in the resident's progress notes. DON stated if the nurses were not comfortable with the BiPap they could get an RT. DON stated after reading the changes in the scope of practice LVN's should not administer BiPap.During a review of Resident 112's Order Summary Report (OSR) dated 4/10/26, the OSR indicated, Resident 112 had an order for BiPap during naps and at bedtime for Acute and Chronic Respiratory Failure (Not enough oxygen in your build and the buildup of carbon dioxide) with Hypercapnia (Having too much carbon dioxide in the blood).During a review of the facility's policy and procedure (P&P) titled Oxygen Administration dated 2010, the P&P indicated, . The purpose of this procedure is to provide guidelines for safe oxygen administration . Documentation . After completing the oxygen set up or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow, route, and rationale. 4. The frequency and duration of the treatment.6. During an observation on 4/7/26 at 9:34 a.m. in Resident 122's room, Resident 122 was lying in bed receiving oxygen via nasal cannula. The nasal cannula tubing was dated 3/30/26.During an observation on 4/8/26 at 10:46 a.m. in Resident 122's room, Resident 122's nasal cannula dated 3/30/26 was rolled up and inside a dignity bag, attached to his head rail.During an interview on 4/8/26 at 10:46 a.m. with CNA 5, CNA 5 stated Resident 122's nasal cannula dated 3/30/26 was in dignity bag. CNA 5 stated that only nurses and RT's change nasal cannula tubing.During an interview on 4/10/26 at 9:56 a.m. with DON, DON stated that her expectation was that the nasal cannula tubing was changed every seven days, as per the physician orders. DON stated it was important to change the nasal cannula tubing per physician order, every seven day for infection prevention.During a review of Resident 112's Order Summary Report (OSR) dated 4/10/26, the OSR indicated, Resident 112 had an order for oxygen at two to three liters by Nasal Cannula continuously and order for when oxygen is in use to change humidifier (water used when administering oxygen) every seven days and tubing as needed every day shift (morning shift) every Sunday.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food that is palatable and attractive, for three of 49 sampled residents (Residents 33, 83, and 119) when residents complained the food lacked flavor, tasted bad or refused to eat their meal.These failure resulted in Resident 33 and 119 not eating all of their lunch and had the potential for unintended weight loss.During an observation and interview on 4/7/26 at 11:59 a.m. with Resident 119 in Resident 119's room, Resident 119 was sitting up in bed with a regular diet meal tray, on her bedside table, consisting of chopped chicken, potatoes, green beans, and a cup of hot chocolate. Resident 119 stated that she did not like the food. Resident 119 stated that the coffee did not taste good and that is why she requests hot chocolate. Resident 119 stated that the potatoes do not have a taste. Resident 119 stated that the green beans do not taste good. Resident 119 stated that she tells the staff she does not like the food, but they keep bringing it to her. Resident 119 stated that she would prefer to eat a peanut butter and jelly sandwich. During an observation on 4/8/26 at 12:30 p.m. a test tray (sample of food given to residents for surveyors to taste) for a regular diet and a puree diet were observed. The regular diet test tray had one slice of ham, light brown beans, translucent whitish-greenish cabbage, and a square of yellow cornbread. The beans and cabbage were served in residual cooking liquid which was on the plate and made the cornbread and ham wet. The ham tasted salty. The cabbage tasted like it had no flavor or seasoning. The beans tasted like they had no flavor or seasoning. The cornbread tasted like plain cornbread. During an observation on 4/8/26 at 12:35 p.m. the puree (food is blended into a smooth mashed potato like consistency) diet test tray had a formed pink food item (ham) with brown liquid on top (gravy), there was a shiny greenish-brown, more liquid like, food item (cabbage), light brown formed food item (beans) with brown liquid on top, and there is a ball of yellow food item (cornbread) with brown liquid on top. The ham tasted salty. The cabbage tasted like it had no flavor or seasoning. The cabbage was gelatinous (gel-like consistency) in consistency. The beans tasted like they had no flavor or seasoning. The cornbread was thick and sticky with a grainy texture and tasted like plain cornbread. During an observation and interview on 4/8/26 at 12:48 p.m. with the Administrator (ADM), the ADM sampled the regular diet and puree diet test trays for lunch. The ADM stated the puree test tray did not taste as good as the regular diet test tray. The ADM stated the puree diet and regular diet should taste the same. During an interview on 4/8/26 at 4:11 p.m. with Resident 33, Resident 33 stated that he did not enjoy lunch. Resident 33 stated the cabbage was soggy and the beans had no flavor. Resident 33 stated that he only ate the ham and was ready to eat again. During an interview 4/9/26 at 2:50 p.m. with Certified Dietary Manager (CDM), the CDM stated the puree foods should have mashed potato consistency, be colorful, and taste good. The CDM stated sometimes thickener (a substance that increases the thickness of food without substantially altering its taste) used for puree diet changes the way the food tastes. The CDM stated that it should not change it to where it tastes horrible. The CDM stated the puree diet should hold its form and should look like a scoop. The CDM stated the puree diet served at lunch on 4/8/26 was not normal for the facility. The CDM stated if the puree diet kept its form, was the consistency of mashed potatoes, and tasted good then it met her expectations. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 4/9/26 at 4:12 p.m. a sample coffee was provided by the facility. The coffee had a slight taste but mostly tasted like hot water. During an interview on 4/10/26 at 9:10 a.m. with the Registered Dietician Consultant (RDC), the RDC stated that puree diet should be completely smooth, without lumps, like a pudding texture. The RDC stated that puree food should mostly maintain its form. The RDC stated that the puree test tray looked like it had ham meat possibly, maybe yellow corn and green beans, and was not sure what the tan food item was. The RDC stated the puree consistency at lunch on 4/8/26 did not look very appetizing. The RDC stated the facility should follow the recipes and measure ingredients with precise measurement. The RDC stated if there was too much water or thickener used in pureed food it could affect the way the food tasted and make it less palatable (pleasant to taste). The RDC stated that using too much water or thickener in pureed food could reduce the nutrients of the food and lead to weight loss or malnutrition. The RDC stated her expectation was for the cook to drain off any additional water or juice from the cabbage because it could dilute the flavor which would affect palatability. During an interview on 4/10/26 at 10:09 a.m. with the Director of Nursing (DON), the DON stated that food should have nice portions, different food types should not run together, and food should appear presentable and be palatable. The DON stated if food was not presentable or palatable, the residents could refuse to eat. The DON stated that if residents refused to eat there was potential for weight loss. During a review of the facility's menu titled WEEK 1 WINTER 2025 dated 4/5/26, the menu indicated, .TUESDAY [4/7/26] . NOON . SCALLOPED POTATOES . GREEN BEANS . WEDNESDAY [4/8/26] . NOON . BAKED HAM SEASONED WHITE PEAS STEAMED CABBAGE CORNBREAD/[NAME] [margarine] . During a record review of Resident 33's admission RECORD, the AR indicated, Resident 33 was admitted to the facility on [DATE]. During a review of Resident 33's Minimum Data Set (MDS- a federally mandated process for clinical assessment of all residents of long term care nursing facilities) dated 3/27/26, the MDS indicated, Resident had a Brief Interview for Mental Status (BIMS - an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life, a score of 0 – 7 indicated severe impairment, 8 – 12 indicated moderate impairment, and 13 – 15 indicated minimal to no impairment) score of 12. During a record review of Resident 83s AR, the AR indicated, Resident 83 was admitted to the facility on [DATE]. During a review of Resident 83's Order Summary Report (OSR) dated 4/10/26, the OSR indicated, . Regular diet . During a review of Resident '83s MDS dated 2/20/26, the MDS indicated, Resident 83 had a BIMS score of 6. During a record review of Resident #119's AD, THE AR indicated, Resident 119 was admitted to the facility on [DATE]. (continued on next page)

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	055410	A. Building B. Wing	04/10/2026

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 119's OSR dated 4/9/26, the OSR indicated, . Regular diet . During a review of Resident 119's MDS dated 2/20/26, the MDS indicated, Resident 119 had a BIMS score of 3. During a review of the facility's policy and procedure (P&P) titled Food and Nutrition Services dated 10/2017, the P&P indicated, . Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food tastes and appears palatable and attractive .

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to permit a resident to return to the facility following hospitalization for one of four sampled residents (Resident 142) when Resident 142 was not re-admitted back to the facility on [DATE].This failure violated Resident 142's right to return to the facility and had the potential to result in delayed placement and care.Findings:During a review of Resident 142's admission Record (AR- a summary of information regarding a resident which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the AR indicated, Resident 142 was admitted to the facility on [DATE] with diagnoses that included epilepsy unspecified non intractable without status epilepticus (a brain condition that causes recurring seizures), unspecified sequelae of nontraumatic intracerebral hemorrhage (long-term or permanent physical, cognitive, and emotional impairments that remain after the initial brain bleeding, swelling, and treatment have stabilized), paroxysmal atrial fibrillation (temporary, irregular, and often rapid heart rhythm originating in the upper chambers), nontraumatic intracranial hemorrhage (a sudden, spontaneous bleeding inside the skull not caused by a physical impact/injury), cognitive communication deficit (difficulty with speaking, listening, reading, or writing caused by thinking problems (memory, attention, organization) rather than language knowledge itself), major depressive disorder (serious mental health condition causing persistent, intense sadness or a loss of interest in activities).During a review of Resident 142's Minimum Data Set [MDS a resident assessment tool used to identify cognitive (mental processes) and physical functional level assessment] dated [DATE], the MDS indicated, Resident 142's Brief Interview for Mental Status (BIMS screening tool used to assess resident cognitive level) score was 2 out of 15 (0 - 7 indicated severe cognitive impairment [memory loss, poor decision making skills] 8-12 moderate cognitive impairment, (13 -15) cognitively intact) which indicated Resident 142 was severely impaired.During an interview on [DATE] at 9:17 a.m., with the admission Coordinator (ADC), the ADC stated when Resident 142 was sent to hospital, the hospital sent clinical updates and Resident 142 was followed until ready for discharge back to facility. The ADC stated whenever a resident is to return to the facility from the hospital, the hospital sends discharge orders (information that includes medication orders, diet, diagnoses, clinical information) and then admission paperwork is processed. The ADC stated the hospital sends a transfer time and the resident is transferred back to facility. The ADC stated if a resident was on medical transfer, they are placed on a bed hold for 7 days, the bed is held with all their Items. The ADC stated Resident 142 was sent to hospital due to a Change of Condition (COC), and clinical update was received from the hospital for Resident 142. The ADC stated after a review of the clinical update, Resident 142 had a big COC, was on restraints and was started on new medications quetiapine (medication is used to treat certain mental/mood disorders) for his behaviors. The ADC stated the medication was prescribed for Resident 142's agitation and Resident 142 also had dementia. The ADC stated a meeting was held, in which the Director of Nursing (DON), ADC and the Administrator were in attendance. The ADC stated the clinical information and medications were reviewed during the meeting and it was agreed upon that the facility could not accommodate Resident 142 because of the new behaviors and the new medications. The ADC stated the facility does not use physical and chemical restraints, the facility felt it was not safe for Resident 142 to return to the facility due to inability to provide the level of care needed for Resident 142. The ADC stated if a resident is on quetiapine, there should be a proper diagnosis, and the facility does not use the medication quetiapine for agitation. The ADC stated Resident 142 was already getting ready to discharge home when the COC occurred. The ADC stated the facility does not use bed alarms, physical or chemical restraint. The ADC stated it was discussed with the Case Manager from CRMC that the facility was unable to accept Resident 142 and Resident 142 was declined in the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	{named}electronic system (ES- a referral system).During an interview on [DATE] at 10:01 a.m., with the DON and the ADM, the DON stated when a resident has a COC, the physician is notified, order would be received from the physician to send the resident to a higher level of care, the responsible party (RP) is notified, an evaluation , the POLST with physician order, is sent when the resident is sent to high level of care for evaluation and treatment. The DON stated if is a medical transfer, the resident is placed on a bed hold for 7 days and within 4 hours, the Licensed Nurse (LN) calls the hospital to find out the resident's status. The DON stated if the resident is admitted , orders are discontinued as well as resident's medication, the facility waits for case management, and the ADC reviews referral through {named}ES. The DON stated that when the resident is returning to the facility, the resident would be a readmit, if gone longer than 24 hrs. The DON stated the facility does not admit anybody on restraints, on medications that could cause potential harm to another resident or danger to the resident himself. The DON stated Resident 142 was in the facility short term, was to be discharged 2 days after he was transferred to the hospital. The DON stated Resident 142 had a COC, he was not at his baseline, the physician was notified, and Resident 142 was sent to the emergency room (ER) on [DATE]. The DON stated the 4-hour call was placed, and report received indicated Resident 142 was transferred via helicopter to AMC. The DON stated Resident 142 was admitted for brain bleeds. The DON stated medications were discontinued and Resident 142 was discharged ; bed hold was stopped on 4/2. The DON stated when Resident 142 was to be discharged from hospital, he was placed on multiple medications and had agitation. The RP informed the facility Resident 142 would require more care based on his diagnosis. The DON stated Resident 142 was not permitted to return to the facility following hospitalization due to his diagnosis. The DON stated the facility considered his new medications to be chemical restraints. The DON stated the facility was not able to provide care for residents on chemical or physical restraints.During an interview on [DATE] at 10:01 a.m., with the DON and the ADM, the ADM stated the facility had available beds at this time but the facility made the decision not to re-admit Resident 142 back due to the new medications.During a review of Resident 142's progress note, dated [DATE], the note indicated, . SBAR- Change in Condition.RP {name} at bedside, requesting resident to be sent out d/t weakness beyond baseline. MD {name} notified with new order to send to AMC. Resident discharged at 1205 via {named} ambulance. RP accompanied resident.During a review of Resident 142's progress note, dated [DATE], the note indicated, . general note- Per AMC ER, resident was transferred to CRMC via Skyline for dx of brain bleedDuring a review of Resident 142's progress note, dated [DATE], the note indicated, . Discharge Summary- Spoke with RP {name}, stated resident was admitted to {named hospital} with R intercranial hemorrhageDuring a review of facility document no title dated [DATE], the document indicated . Resident 142's was admitted to the hospital [DATE].Roughly 20 days of medi-care days left.During a review of facility document titled Census List (CL) dated [DATE], the CL indicated . Resident 142's was transferred in from hospital on [DATE], transferred out to hospital on [DATE] and was discharge - status stop billing on [DATE].During a review of facility document provided ES no date, the ES indicated the facility and the {named} hospital exchanged information on Resident 142's discharge with the facility. The ES indicated .XXX[DATE] OT/PT notes dated 03/30 attached @10:10 a.m., MD progress notes dated 03/31 attached @10:11 a.m., .XXX[DATE]. {facility name} is selected to provide services for this patient @10:58 a.m., MAR attached @11:10 a.m., updated clinicals attached @11:15 a.m. Resident 142's was discharged elsewhere on [DATE] @3:30 p.m.During an interview on [DATE] at 4:00 p.m., with the DON, the DON stated the facility no longer had access to the documents in the ES. The DON stated the facility was unable to provide the discharged documents from the hospital since the facility did not accept Resident 142. The DON stated the PN-Discharge Summary was the Discharge document available. The DON stated the Bed Hold indicated in the CL was the documentation available. When asked if there was a facility-initiated discharge after the facility determined Resident 142 was declined, The DON stated Resident 142 had already been discharged when he was admitted to the hospital and that was indicated in the PN- Discharge (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	summary dated [DATE].During a review of the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, no date, the P&P indicated, . Policy interpretation and implementation. 1. All residents/ representatives are provided written information regarding the facility and state federal policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided with written notice about these policies at least twice: a. notice 1: well in advance of any transfer (e.g., in the admission packet and b notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours).5. The requirement that residents be permitted to return to the facility following hospitalization of therapeutic leave applies to all residents regardless of payer source. 6. Residents will seek to return to the facility within the bed hold period defined in the state plan are allowed to return to their previous room if available. 7. Residents who seek to return to the facility after the state bed hold has expired (or when state law does not provide for bed holds) are allowed to return to their previous room if available or immediately to the first available bed in the semi-private room provided that the resident: a. still requires the services provided by the facility: and b. is eligible for Medicare skilled nursing facility or Medicaid nursing facility services.9. If the facility determines that a resident cannot return, the facility must comply with the requirements for facility-initiated discharges.12. Following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/ behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set Assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for two of four sampled residents (Resident 133 and Resident 134) when:1.Resident 133's upper and lower extremities were coded inaccurately in the MDS assessment.This failure had the potential to result in Resident 133's care needs not met.2. Resident 134's diagnosis of anxiety was not coded in the MDS assessment.This failure had the potential for Resident 134's need not met and changes in behavior not monitored. Findings: 1. During a review of Resident 133's admission Record (AR-document containing resident profile information) dated 4/9/26, the AR indicated Resident 133 was admitted to the facility on [DATE] with diagnoses which included osteoarthritis (occurs when the smooth, protective cartilage cushioning the ends of the bones wears down causing bones to rub together) of left hip and right knee, rheumatoid arthritis (chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), and muscle weakness. During a concurrent observation and interview on 4/7/26 at 10:07 a.m. during the initial tour in Resident 133's room, Resident 133 was observed lying in bed with legs flexed crossed. Resident 133 stated, I am not comfortable, this is not helping me, I need to be repositioned. Resident 133 stated she had leg pain all the time because of her arthritis. During a concurrent interview and record review on 4/8/26 at 11:28 a.m. with Minimum Data Set Nurse (MDSN), the MDSN reviewed Resident 133's MDS assessment dated [DATE] Section GG (Functional Abilities). The MDSN stated Resident 133 was dependent on staff with toileting, shower/bathe, and not attempted to walk due to medical condition or safety concern. The MDSN stated he coded Resident 133 as not having impairment of upper and lower extremities. The MDSN stated he did not code Resident 133 as having impairment to her extremities and he should have. The MDSN stated he did not perform bedside assessment on Resident 133, stated I based it on the therapy evaluation. The MDSN stated it was his responsibility to ensure assessments were accurate in order to provide the care needed by residents. During an interview on 4/9/26 at 8:05 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was familiar with Resident 133's care. CNA 4 stated Resident 133 was dependent on staff with her activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, and toileting a person performs daily to care for themselves). CNA 4 stated Resident 133 requires assistance because she complains of pain all the time and she gets stiff. During an interview on 4/9/26 at 10:33 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was familiar with Resident 133. LVN 2 stated Resident 133 was dependent on staff to do all her ADL needs. LVN 2 stated Resident 133 was always complaining of pain and did not want to do anything for herself. 2. During a review of Resident 134's AR dated 4/9/26, the AR indicated Resident 134 was admitted to the facility on [DATE] with diagnoses which included anxiety (feeling of worry, nervousness, or unease about a future event or something with an uncertain outcome, palliative care (specialized medical care focused on relieving the symptoms, pain, and stress of a serious illness), and depression (a common, serious mental health disorder characterized by a persistent feeling of sadness, emptiness, or loss of interest in activities). During an observation on 4/7/26 at 9:55 a.m. during initial tour in Resident 134's room, Resident 134 was observed lying in bed with eyes closed and covered with blanket. Resident 134 did not respond when spoken to. During a concurrent interview and record review on 4/8/26 at 11:40 a.m. with MDSN, MDSN reviewed Resident 134's MDS assessment dated [DATE] Section I (Active Diagnoses). The MDSN stated Resident 134 was admitted to Hospice Care and was diagnosed as having anxiety on /11/26. The MDSN stated she did not code Resident 134 as having anxiety and she should have. The MDSN stated it was her responsibility to ensure MDS assessments were accurate. During an interview on 4/9/26 at 8:10 a.m. with CNA 4, CNA 4 stated she was familiar with Resident 134's care. CNA 4 stated Resident 134 was able to understand simple (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	questions and answer simple words. CNA 4 stated Resident 134 has behaviors like hitting, kicking and yelling at staff. During a concurrent interview and record review on 4/9/26 at 10:45 a.m. with LVN 2, LVN 2 reviewed Resident 134's clinical records. LVN 2 stated Resident 134 has a diagnosis of anxiety and was started on lorazepam (medication used to treat anxiety) when admitted under hospice care (specialized, comfort-focused care for individuals with a terminal illness who are likely in their last six months of their life, focusing on quality of life rather than curing the illness). During an interview on 4/10/26 at 11:15 a.m. with the Director of Nursing (DON), the DON stated, I do not verify accuracy, I only verify completion in the MDS. The DON stated her expectation was for MDS assessments to be accurate. The DON stated she expects each person completing a section in the MDS to ensure their assessments are accurate. During a review of facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, revised date 11/19, the P&P indicated, .Any health care professional who participates in the assessment process is qualified to assess the medical, functional and/or psychosocial status of the resident . Any person who completes any portion of the MDS assessment . is required to sign the assessment certifying the accuracy of that portion of that assessment . The information captured on the assessment reflects the status of the residen . During a review of facility's policy and procedure (P&P) titled, Resident Assessments-Conducting Resident Interviews revision date 10/24, the P&P indicated, .All residents capable of any communication should be asked to provide information . Resident interviews are attempted for those areas of the MDS that are designated as such. If a resident interview is not conducted due to reasons documented in that section, Staff Assessments of that item set are conducted .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a Preadmission screening and Resident Review (PASARR-a federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) level I screening for one of five sampled residents (Resident 100) when Resident 100's PASARR level I screening dated 6/3/24 did not indicate Resident 100's diagnosis of anxiety disorder (mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life) and no PASARR Level I screening was completed.This failure had the potential for Resident 100 to not receive the appropriate services related to her mental disorders. Findings: During a review of Resident 100's admission Record (AR- a document containing resident profile information), dated 4/8/26, the AR indicated, Resident 100 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial weakness, numbness, or reduced motor control on one side of the body)), and dementia (a progressive state of decline in mental abilities). During a concurrent observation and interview on 4/7/26 at 10:04 a.m. during initial tour in Resident 100's room, Resident 100 was lying in bed and observed biting her fingernails. Resident 100 appeared clean and appropriately dressed. Resident 100 stated she did not remember how long she had been in the facility. Resident 100 stated staff are good but some of the newer certified nursing assistants (CNAs) need more training, Resident 100 refused to elaborate her statement. During an interview on 4/8/26 at 3:17 p.m. with the admission Coordinator (AC), the AC stated she had been the AC for more than a year. The AC stated she reviewed Resident's PASARR when admitted from the hospital. The AC stated she only completes PASARR assessments for hospice residents admitted from their home. The AC stated she did not do any other PASARR assessments. The AC stated PASARR was completed for residents with new order for psychotropic medications (medications that change brain chemistry to manage health conditions, affecting mood, thought patterns, and behavior). During a concurrent interview and record review on 4/8/26 at 3:40 p.m. with Licensed Vocational Nurse/Assistant Director of Nursing (LVN/ADON) she stated she was responsible in completing PASARR assessment for significant change in condition and residents admitted or discharged from hospice services. LVN/ADON stated the AC was responsible in reviewing PASARR assessments for accuracy, review diagnoses and medications. LVN/ADON stated the AC was responsible in completing level I PASARR assessment when a PASARR assessment was inaccurate. LVN/ADON reviewed Resident 100's PASARR assessment dated [DATE] and stated, The PASARR was invalid, it was not supposed to be done. LVN/ADON stated there should have been another PASARR level I assessment completed to correct the issue but it was not done. LVN/ADON stated PASARR was important to ensure residents with mental illness received proper treatment needed. During a review of Resident 100's Preadmission Screening and Resident Review (PASRR) Level I Screening dated 6/3/24. The Preadmission Screening and Resident Review, indicated, . Section III - Serious Mental Illness - Definition . Does the Individual have a serious diagnosed mental disorder such as . anxiety disorder . No . During an interview on 4/10/26 at 11:20 a.m. with the Director of Nursing (DON), the DON stated she did not do PASARR assessments. The DON stated the AC was responsible in reviewing PASARR for accuracy and completeness. The DON stated her expectation was to complete another assessment if there was discrepancy or error in the PASARR Level I assessment. The DON stated PASARR assessment are important in order for the facility to refer resident to the appropriate agency and receive the proper care needed. During a review of the facility's policy and procedure (P&P) titled, Preadmission SCREENING AND RESIDENT REVIEW (PASRR), undated. The P&P indicated, . A Level I PASRR screen must be completed for all applicants before admission, unless state process provides otherwise. (continued on next page)

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	055410	A. Building B. Wing	04/10/2026

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission staff must review PASRR documents prior to admission . The facility will monitor for significant changes in mental, behavioral, or physical status For transfers and readmissions, the facility will review existing PASRR documentation .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

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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 ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for one of eight sampled residents (Resident 44), when the facility did not have a care plan to monitor for side effects of Plavix (antiplatelet - blood thinners that prevent blood cells called platelets from sticking together and forming dangerous clots in arteries). This failure placed Resident 44 at risk for not being monitored for side effects of antiplatelet medication such as bleeding, bruising, and passing out.Findings: During a concurrent observation, on 4/8/26 at 10:18 a.m. in Resident 44's room. Resident 44 was in bed sleeping with tray table across her bed. During a review of Resident 44's admission Record (AR), (a document containing pertinent resident profile information) dated 4/9/26, the AR indicated, Resident 44 was admitted to the facility on [DATE], with diagnoses which included Monoplegia of lower limb affecting right side (paralysis or severe weakness of one leg, often caused by nerve damage, spinal cord injury, or stroke [occurs when blood flow to part of the brain is blocked or a blood vessel bursts]), Major Depressive Disorder (a mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities that lasts for at least two weeks), Anemia (a common blood condition where you lack enough healthy red blood cells or hemoglobin to carry adequate oxygen to body's tissues), and Type 2 Diabetes Mellitus (DM- a chronic condition where the body cannot effectively use insulin (insulin resistance) or produce enough of it, leading to high blood sugar levels). During a review of Resident 44's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs), assessment dated [DATE], the MDS assessment indicated, Resident 44's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 0 to 15 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 9 out of 15 which indicated Resident 44 had moderate cognitive deficits. During a review of Resident 44's Medication Administration Record (MAR), dated 4/8/26, the MAR indicated, Resident 44 was prescribed Plavix Oral Tablet 75 MG (unit of measure) . by mouth one time a day for clot prophylaxis (to prevent blood clots) . During a concurrent interview and record review on 4/8/26 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 44's Care Plans (CP), dated 4/8/26 were reviewed. The CP indicated, a CP for antiplatelets was not created. LVN 3 stated, . a CP was required for all residents taking an antiplatelet, the CP should include what to side effects to monitor for such as bleeding or bruising . During an interview on 4/10/26 at 11:10 a.m. with the Director of Nurses (DON), the DON stated, . when Residents are taking antiplatelets a CP is required to inform staff what side effects to monitor for . the CP is in place for the safety of the residents. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered, (undated), indicated, . a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psycho social and functional needs is developed and implemented for each resident . includes measurable goals and objectives, describes the services that are to be provided . reflects currently recognized standards of practice for problem areas and conditions .

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	055410	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 timely revise and implement a person-centered comprehensive care plan for one of five sampled residents (Resident 101) when Resident 101's care plan for oxygen (O2- a colorless, odorless and tasteless gas essential for life) was not updated and did not accurately reflect the physician's order for Resident 101's use of oxygen.This failure had the potential to result in Resident 101's care needs to not be met.Findings:During an observation on 4/7/26 at 9:37 a.m. in Resident 101's room during the initial tour, Resident 101was sitting in her wheelchair with a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing) and was set to 1.5 L/M (liter per minute- a unit of measurement for the flow rate of oxygen).During a review of Resident 101's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/8/26, the AR indicated, Resident 101, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included .chronic obstructive pulmonary disease (COPD- is a progressive, long-term lung disease that makes it hard to breathe), Chronic respiratory failure with hypoxia (when the lungs cannot adequately transfer oxygen from the air into the bloodstream, resulting in dangerously low oxygen levels), heart failure (when the heart muscle is too weak or stiff to pump blood efficiently, failing to meet the body's need for oxygen) .During a review of Resident 101's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 2/11/26, the MDS section C indicated Resident 101 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 12 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview. The BIMS score indicated Resident 101 had moderate impairment.During a review of Resident 101's Order Summary Report (OSR- indicates the physician order), the OSR indicated .O2 @ 2L/M via nasal cannula PRN as needed for SOB. order start date 3/29/26.During a review of Resident 101's CP, the CP indicated .Interventions. Give 2L/M via oxygen nasal cannula as order. date initiated 12/7/2022. revision date 11/13/2024.During a concurrent interview and record review on 4/8/26 at 11:27 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 101's O2 order dated 3/29/26 and CP with revision date 11/13/2024 were reviewed. LVN 1 stated CP for O2 @ 2L was dated 11/13/2024, and the O2 order was for 3/29/26. LVN 1 stated Licensed Nurse (LN)s were responsible for revising the CP. LVN 1 stated the CP should have been revised. LVN 1 stated it should be clear the care plan LNs were using for the residents because it reflects the plan of care for Resident 101.During a concurrent interview and record review on 4/8/26 at 12:07 p.m. with Assistant Director of Nursing (ADON), Resident 101's O2 order dated 3/29/26 and CP with revision date 11/13/2024 were reviewed. The ADON validated the 2L CP was dated 11/13/2024 and 2L O2 order was dated 3/29/26. The ADON stated the CP was not updated or revised. The ADON stated the LNs revise the CP and Minimum Data Set Nurse (MDSN) reviews the CP to ensure orders are matching the CP. The ADON stated the CP should have been updated and revised because it was Resident 101's plan of care. The ADON stated the plan of care should indicate what is going on with Resident 101 as of today.During an interview on 4/9/26 at 2:55 p.m. with the Director of Nursing (DON), the DON stated Resident 101's CP should have been updated and revised to match the needs of Resident 101. The DON stated this was important to avoid confusion and to ensure the right order was followedDuring a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person- Centered, dated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/2022, the P&P indicated, Policy Statement- . 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. Policy interpretation and implementation- . 9. Care plan interventions are chosen only after data gathering, and proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 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 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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	055410	A. Building B. Wing	04/10/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility to provide the necessary services to maintain good grooming and personal hygiene for one of five sampled residents (Resident 13) when Resident 13 was not provided showers on his scheduled days in accordance with his needs and plan of care.This failure resulted in Resident 13 to miss his showers and had the potential to result in skin breakdown and infection.Findings:During interview on 4/7/26 at 9:16 a.m. with Resident 13 in his room, Resident 13 stated They don't bathe me. Resident 13 stated he did not recall the last time he had a bath. Resident 13 stated he wanted a bath because he felt dirty.During a 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 4/9/26, the AR indicated Resident 13 was admitted to the facility from an acute care hospital on 2/2/26 with diagnoses of encounter of attention to gastrostomy(medical procedure that creates a small, artificial opening into the stomach through the abdominal wall), paraplegia (the partial or complete paralysis of the lower half of the body, usually affecting both legs and sometimes the abdomen), full incontinence of feces (the involuntary leakage of solid or liquid stool (poop) from the anus), functional urinary incontinence (the involuntary or accidental leakage of urine due to a loss of bladder control) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).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 3/16/26, the MDS section C indicated Resident 13 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding on a scale of 1-15) score of six (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 13 was severely impaired.During a concurrent interview and record review on 4/8/26 at 12:38 p.m. with the Assistant Director of Nursing (ADON), Resident 13's shower task in the electronic medical records (EMR) from 3/11/26 to 4/8/26 was reviewed. The EMR indicated Resident 13 had showers on Wednesday (Wed) 3/11/26 @ 21:43, Wed 3/18/26 @21:25, Saturday (Sat) 3/21/26 @ 21:59, Wed 3/25/26 @ 18:41, Sat 3/28/26 @22:59, and Sat 4/4/26 @22:59. The EMR indicated all other days were checked off as Not Applicable. The ADON stated the Director of Staff Development (DSD) was responsible for the CNA skin monitoring worksheet (shower sheet). The ADON stated resident showers were scheduled and that residents should receive showers twice a week. The ADON Resident 13's shower days were Wednesdays and Saturdays. The ADON stated the expectation was for the Certified Nursing Assistant (CNA)s to document the showers completed in the task and in the shower sheet. The ADON stated the shower sheet is completed to ensure there are no skin issues on the resident. The ADON stated Resident 13's showers were not consistent, sometimes there was 7 days difference indicating Resident 13 did not shower for 7 days. The ADON stated expectation from the CNAs was when a shower was completed it should be documented and when refused, the refusal should be documented. The ADON stated the CNAs documented not applicable, which indicated the shower did not apply or Resident 13 did not need a shower. The ADON stated it was important that the CNAs provide shower Resident 13 for hygiene purposes, to ensure Resident 13 was clean and dry. The ADON stated Resident 13 was a stroke patient (happens when blood flow to part of the brain is blocked or a blood vessel in the brain bursts, which cuts off oxygen, causing brain cells to die quickly and leading to sudden paralysis, speech loss, or death) with history of depression who had a peg tube (a feeding tube inserted through the skin of the abdomen directly into the stomach to deliver nutrients, fluids, and medications), and was totally dependent on the facility staff for activities of daily living (ADL-fundamental, routine self-care tasks essential for independent living, health, and safety, typically including bathing, dressing, eating, transferring (mobility), toileting, and continence). The ADON stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this failure could lead to skin breakdown for Resident 13.During a concurrent interview and record review on 4/9/26 at 9:38 a.m. with the DSD, Resident 13's shower sheet and shower task in the EMR were reviewed. The shower sheet indicated Resident 13 had showers on Wed 3/11/26, Wed 3/18/26, Sat 3/21/26, Wed 3/25/26, Sat 3/28/26, and Sat 4/4/26. The DSD stated the shower sheet is completed when a resident refuses showers. The DSD stated there was no refusal on any of the shower sheets. The DSD validated the shower days on the shower task and stated the other days indicated Not applicable. The DSD stated Not applicable meant it did not happen. The DSD stated it was important to have Resident 13 take a shower and honor his preferences. The DSD stated if a shower was not done, the CNAs could perform a bed bath. The DSD stated if Resident 13 refused the shower, the CNAs should document, and if Resident 13 continued to refuse, the resident should be encouraged, if the refusal happened consistently, the family member should be informed. The DSD stated everything should be done to encourage the residents. The DSD stated Resident 13 could develop skin problems which could lead to complications to open areas of the skin and Resident 13 could get sick.During an interview on 4/9/26 at 10:29 a.m. with the Infection Preventionist (IP), the IP stated the expectation was the CNAs should have offered a bed bath. The IP stated it was important because Resident 13 had an opening due to the peg tube, therefore he needed to take his bath. The IP stated the failure could potentially lead to accumulation of bacteria and Resident 13 could have body odor. During an interview on 4/9/26 at 2:55 p.m. with the Director of Nursing (DON), the DON stated the CNAs should have offered bed bath, and document refusals. The DON stated staff should have offered Resident 13 a shower three times on the shift. The DON stated, Not applicable meant does not apply. The DON stated Resident 13 needed to have a shower to maintain hygiene. The DON stated the failure to provide Resident 13 a shower could lead to skin breakdown and infection for Resident 13.During a review of the facility policy and procedure (P&P) titled, Dignity, no date, indicated, . Procedure.2. residents will be offered and assisted with showering or bathing in a manner that preserves privacy, dignity, and comfort.During a review of the facility P &P titled, Resident Rights, dated 12/2021, indicated, .federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: (b) be treated with respect, kindness and dignity.During a review of the facility P &P titled, Resident Bathing, no date, indicated, .Policy: Residents will receive bathing and hygiene assistance based on their needs, preferences, care plan and level of independence. Bathing will be provided in a safe, respectful and dignified manner that protects privacy, promotes comfort, and support skin integrity and infection control. Procedure: 1. Review the resident's care plan and any special instructions before bathing 6. Wash gently, rinses well and dry thoroughly, especially skin folds and perineal area. 7. Observe the skin for redness, bruising, rashes, open areas or other concerns . 10. If the resident refuses bathing, respect the refusal, offer alternatives, report repeated refusals, and document accordingly. 11. Document the type of path given, level of assistance provided, resident tolerance, refusals, and any skin concerns.

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	055410	A. Building B. Wing	04/10/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure bed rails were properly maintained in safe working condition for one of five sampled residents (Resident 68) when Resident 68's bedrail was not functional and not securely locked.This failure placed Resident 68 at risk for injury such as falls, skin tears and possible entrapment.Findings:During a concurrent observation and interview on 4/7/26 at 9:37 a.m. with Resident 68 in her room, Resident 68 was lying bed, head of bed elevated, and bilaterial bed rails up. Resident 68 stated I just need a new bed. Resident 68 was observed facing the right side, holding onto the right bed rail. Resident 68 stated my bed rail broke, the one on the left when they turn me over, I have to grab it, and it does not stay up. Resident 68's bed rail on the left side was evaluated and noted to not hold steady. The bed rail was not securely locked and would drop once hands were placed on it. Resident 68 stated it is scary, I have to catch it, I am partially blind, I have glaucoma (an eye condition that damages the nerve in the eyes which can lead to vision loss or blindness). Resident 68 stated the bed rail was not securely locked for about 2-3 months. Resident 68 stated she informed the Licensed Nurse (LN)s and the Certified Nursing Assistant (CNA)s of the non-functional bed rail. Resident 68 stated maintenance department was aware because it was documented in the maintenance log (ML). Resident 68 stated I asked for a new bed 7 times and nobody has done anything about it. Resident 68 stated the Maintenance Director (MD) was aware of the non-functional bed rails.During a concurrent observation and interview on 04/07/2026 at 9:54 a.m., CNA 1 and CNA 2 entered Resident 68's room to reposition Resident 68. The CNAs repositioned Resident 68 without the use of the bed rail. When asked if she was aware of the broken bed rail, CNA 1 stated she was not aware the bed rail was broken. CNA 1 proceeded to evaluate the bed rail on the left and stated it was not securely locked. CNA 1 stated she was not aware how long the bed rail was not functional. CNA 1 stated she had worked with Resident 68 for the last 3 weeks. When asked how she turns or changes Resident 68, CNA 1 stated I am used to holding her hand because Resident 68 likes to hold onto something. CNA 1 stated the unlocked bed rail was a safety issue. CNA 1 stated she should have checked the bed rail to ensure it was securely locked. CNA 1 stated it was important so that Resident 68 did not fall out of bed or had an accident.During a concurrent observation and interview on 04/07/2026 at 10:03 a.m., the Maintenance Assistant (MA) entered Resident 68's room to evaluate Resident 68's bed rail. The MA confirmed the bed rail on the left side was not securely locked. The MA stated he was just notified the bed rail was not functional.During an interview on 4/8/26 at 11:06 a.m. with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 68 was blind in both eyes, has right sided weakness, and used bed rail as a safety net (sense of safety). LVN 1 stated Resident 68 did not roll from side to side. LVN 1 stated she was not aware Resident 68's bed rail was not functional. LVN 1 it was important Resident 68's bed rail was functional for safety issues. LVN 1 stated the expectation from facility staff was to have the side rails checked daily because Resident 68 had vision impairment. LVN 1 stated Resident 68 would think the bed rail was close and could be reaching further, which could lead to a fall.During a concurrent interview and record review on 4/8/26 at 1:06 p.m. with the MD, the MD stated the beds and bed rails were inspected quarterly or anytime a room was empty and the facility was expecting a new resident or when a CNA or LN informs there was an issue. The MD stated sometimes when there was a complaint, the maintenance department would usually just resolve the issue without documentation in the ML. The MD stated the last time Resident 68's bed rail was inspected was 1/7/26. The MD stated the next maintenance was due on the month of April 2026. The MD stated there was no definite date and schedule to inspect the bed rails. The MD stated the maintenance should have been completed the week of 4/6/26- 4/10/26 but the maintenance department was not able to complete it. The ML was reviewed with the MD. The ML indicated there were request orders (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055410	A. Building B. Wing	04/10/2026

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Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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	055410	A. Building B. Wing	04/10/2026

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	055410	A. Building B. Wing	04/10/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functions- report all hazardous conditions and equipment to the charge nurse/ nurse supervisor immediately. Equipment and supply functions report defective equipment to the charge Nurse/ Nurse supervisor utilize lockout/ tag out as directed.During a review of the facility's document titled, Job Description, Licensed Practical (Vocational) Nurse, 08/2024, the document indicated . Duties and Responsibilities- safety and sanitation functions- Ensure the residents environment remains as free of accident hazards as possible. Ensure each resident receives adequate supervision and assistive devices to prevent accidents During a review of the facility's document titled, Job Description, Registered Nurse, 07/2024, the document indicated . Duties and Responsibilities- safety and sanitation functions- Ensure the residents environment remains as free of accident as possible. Ensure each resident receives adequate supervision and assistive devices to prevent accidents During a review of the facility's document titled, Job Description, Director of Maintenance, 07/2024, the document indicated . Duties and Responsibilities- Ensure the safe and proper functioning of the environment and equipment necessary to care for the resident population in the facility. Evaluate and document facility maintenance and equipment need. Maintenance Function- Conduct ongoing inspection of facility to identify areas and equipment requiring improvement/ repairs. Develop and implement a preventative maintenance program including routine inspection and servicing. Examine equipment, system . to determine needed installation services or repairs.During a review of the facility's document titled, Job Description, Director of Nursing, 07/2024, the document indicated . Duties and Responsibilities- safety and sanitation functions- Ensure the resident environment remains as free of accidents hazards as much as possible and resident receives adequate supervision and assistive devices to prevent accidents. Equipment and supply function- develop and implement procedures for the safe operation of all nursing service equipment . Ensure . equipment . are always maintained on the premises to adequately meet the needs of the resident.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to ensure nurse staffing information was accurately posted when: 1. The actual number of hours worked per shift by Registered Nurses (RNs), Licensed Vocational Nurses (LVNs) and Certified Nursing Assistants (CNAs) was not accurately reflected.2. The actual number of Licensed Staff (RN's, LVNs, and CNAs) was not specifically reflected in the staffing sheets. This failure resulted in an inaccurate posting of daily nurse staffing information and had the potential to result in residents, visitors and the public from determining the number and type of nursing staff providing direct care in the facility. Findings:During a concurrent interview and review of daily staffing hours sheets on 4/9/26 at 1:40p.m. with the Employee Services Representative (ESR), the ESR stated she generated the staffing hour reports each morning, which included RN, LVN and CNA hours and was calculated from midnight to midnight. Upon review of the staffing hours sheet dated 4/8/26, the ESR stated the posted staffing hours reflected projected hours rather than the actual hours worked. The ESR further stated the left side of the sheet represented licensed staff and combined RN and LVN hours, while the right side included CNA and RNA hours. The ESR stated the report did not distinguish individual staff titles, indicating she was aware of staff roles, but the posted document did not identify whether staff were RN's or LVN's. The ESR stated it would be important for family members to know the amount of care being provided and confirmed the posted information did not reflect actual hours worked, but only projected staffing hours. During a concurrent interview and review of daily staffing hours on 4/10/26 at 9:21a.m. with ERS, ERS stated the posting reflected current day (4/10/26) projected staffing and did not include the prior days (4/9/26) actual hours worked. ERS stated the posting was based on scheduled staff, with coverage updated on assignment sheets, including the use of on call staff. ERS stated the posting identified staff as licensed but did not differentiate between RN and LVN and only selected staff (e.g., Director of Nursing (DON) and Minimum Data Set Nurse (MDSN) had titles listed. ERS acknowledged a resident or visitor would not be able to determine which licensed staff were RN versus LVN's based on the posted information. During an interview on 4/10/26 at 1:15p.m. with the DON and administrator (ADMIN), the DON stated staffing numbers were calculated based on the facility census. The ADMIN stated the posted staffing reflected projected rather than actual hours and acknowledged residents and the public would have no way of determining actual staffing based on the posting. During a review of facilities policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, dated August 2022, the P&P indicated, 2. the information recorded on the form shall include the following: f. type (RN, LPN, LVN or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility.g. the actual time worked during that shift for each category and type of nursing staff.h. total number of licensed and non-licensed staff working for the posted shift.

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	055410	A. Building B. Wing	04/10/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of five sampled residents (Resident 84 and Resident 133) drug regimen was free from unnecessary drugs when:1.Resident 84 received Namenda (medication used to improve memory, attention, reason, and language abilities) for memory loss without a written informed consent and monitoring of side effects and behaviors. This failure resulted in Resident 84 receiving medication and not properly informed of the possible side effects which had the potential for Resident 84 to have experienced side effects of medication and changes of behavior without proper monitoring.2. Resident 133 received acetaminophen (medication used to treat pain) tablet as needed for pain and oxycodone HCL (hydrochloride) (opioid prescription medication used to treat pain) tablet as needed for pain daily without pain parameters. This failure had the potential for Resident 133 to not received adequate pain relief which could lead to serious medical condition.1. During a review of Resident 84's admission Record [AR-a document containing resident profile information], dated 4/9/26, the AR indicated Resident 84 was admitted to the facility on [DATE] with diagnoses which included unspecified dementia (a progressive stated of decline in mental abilities), depression (persistent feeling of sadness, emptiness, or loss of interest in activities) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a concurrent observation and interview on 4/7/26 at 9:34 a.m. during initial tour in Resident 84's room, Resident 84 was lying in bed and stated she had been in the facility long enough. Resident 84 stated she did not have any concerns but felt like staff can do better when providing her care. Resident 84 appeared clean and appropriately dressed for the season. During an interview on 4/9/26 at 8:15 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was familiar with Resident 84's care. CNA 4 stated Resident 84 was alert and oriented with confusion. CNA 4 stated Resident 84 had behaviors like physically and verbally aggressive towards staff during care. CNA 4 stated she remember reporting to the charge nurse every time Resident 84 had behaviors. During a concurrent interview and record review on 4/9/26 at 10:48 a.m. with Licensed Vocational Nurse (LV) 2, LVN 2 stated she was familiar with Resident 84's care. LVN 2 reviewed Resident 84's clinical record titled,Order Summary Report, LVN 2 stated Resident 84 was receiving namenda for memory loss. LVN 2 stated she did not find an informed consent for the medication and was not sure if an informed consent was needed. LVN 2 stated informed consent was important to let the family and resident know of the side effects of medications and gives resident and family a chance to decide if they want to continue with the medication. LVN 2 stated the practice was to ensure an informed consent was signed prior to administering psychotropic medications (prescription drugs that alter brain chemicals to manage emotions, thoughts, and behaviors). LVN 2 stated she did not find monitoring of side effects or behavior for the medication. LVN 2 stated it was important to monitor for side effects and behavior to ensure medication was effective. During a concurrent interview and record review on 4/9/26 at 1:41 p.m. with Licensed Vocational Nurse/Assistant Director of Nursing (LVN/ADON), Resident 84's clinical record was reviewed. LVN/ADON stated Resident 84 was taking namenda for memory loss. LVN/ADON stated, The medication classification in pointclickcare (PCC-cloud-based, comprehensive electronic health record platform used in skilled nursing facilities to manage clinical, financial, and administrative operations) was wrong and should have been changed. LVN/ADON stated an informed consent was not needed for the medication. LVN/ADON stated a signed informed consent for psychotropic medications was needed prior to administering medications. LVN/ADON stated, If we go by the medication's classification then we need an informed consent. LVN/ADON stated there was no behavior monitoring and medication side effects in place. During an interview on 4/10/26 at 11:45 a.m. with the Director of Nursing (DON), the DON stated there was no informed consent for Resident 84's use of namenda medication because it was used for memory loss. The DON stated she was sure Resident 84 and family was notified of the medication (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when it was ordered but no informed consent was signed and stated, Per our pharmacist, we do not need an informed consent. The DON stated her expectation was to ensure there was a signed informed consent for all psychotropic medications prior to administering medications. The DON stated they was no monitoring for medication side effects and behavior in place. During a review of facility's policy and procedure (P&P) titled,Informed Consent for Psychotropics Drugs (CALIFORNIA), the P&P indicated, . Physician Healthcare Practitioner: Only physician may obtain informed consent . Discuss material information with the resident/responsible party (RP) prior to initiation of dose or dose increase . Facility Role: Verify (but not obtain) informed consent . Fully inform residents/R of health status . During a review of facility's P&P titled, Resident Rights, revised date 12/21, the P&P indicated, . These rights include the resident's right's to: . be treated with respect, kindness, and dignity . be free from corporal punishment or involuntary seclusion, and or physical and chemical restraints . 2. During a review of Resident 133's admission Record (AR-), dated 4/9/26, the AR indicated Resident 133 was admitted to the facility on [DATE] with diagnoses which included osteoarthritis (often called wear-and-tear- occurs when smooth, protective cartilage cushioning the ends of the bones wears down over time, causing bones to rub together), injury of muscle fascia (thin, tough, elastic connective tissue) and tendons (tough, fibrous, white cords that connects muscles to bones), rheumatoid arthritis (chronic autoimmune disease where the immune system mistakenly attacks joint linings, causing painful swelling, stiffness, and potential bone damage). During a concurrent observation and interview on 4/7/26 at 10:07 a.m. during the initial tour in Resident 133'a room, resident 133 was observed lying in bed with legs flexed and crossed. Resident 133 stated, I am not comfortable, this is not helping med, I need to be repositioned. Resident 133 stated she had leg pain all the time because of her arthritis. During a concurrent interview and record review on 4/8/26 at 3:45 p.m. with LVN/ADON, Resident 133's clinical record was reviewed. LVN/ADON stated Resident 133 was admitted to the facility on [DATE] as a short term and transitioned to long term. LVN/ADON stated Resident 133 had two orders for pain medications and both are as needed. LVN/ADON stated Resident 133 received oxycodone every 4 hours as needed for pain every day with pain scale from 5-9 for the month of April. LVN/ADON stated Resident 133 received tylenol extra strength every 6 hours as needed for pain every day with pain scale from 3-7 for the month of April. LVN/ADON stated there was no pain parameters for both medications. LVN/ADON stated the facility did not use pain parameters, only hospice residents uses pain parameters. LVN/ADON stated she was not sure how licensed nurses decided which pain medication to administer to Resident 133 because there was no pain scale parameters with the medication orders. LVN/ADON stated she was not sure why the facility did not use pain parameters with the as needed pain medications. During an interview on 4/9/26 at 8:05 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was familiar with Resident 133's care. CNA 4 stated Resident 133 complained of pain on her legs and arms all the time. CNA 4 stated she let the charge nurse know every time Resident 133 complained of pain. During an interview on 4/9/26 at 8:35 a.m. with CNA 3, CNA 3 stated she had taken care of Resident 133 and was familiar with her care. CNA 3 stated Resident 133 was always complaining of a lot of pain and constantly asking about her pain medication. CNA 3 stated she always made sure she let the nurse know of Resident 133's request for pain medication. During a concurrent interview and record review on 4/9/26 at 10:35 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she was familiar with Resident 133's care. LVN 2 reviewed Resident 133's medication orders and stated Resident 133 had two pain medication orders and both are as needed with no pain parameters. LVN 2 stated she usually asked Resident 133 what pain medication she wanted and needed. LVN 2 stated, I think we need pain parameters in order to know which medication to give to residents. During an interview on 4/9/26 at 3:52p.m. with Registered Nurse (RN)1, RN 1 stated she asked Resident 133 her pain scale and location and administer pain medication based on the pain scale. RN 1 stated she administer the opioid medication for pain scale from 5-7, acetaminophen for pain scale from 1-4 and call the doctor for pain of 9-10. RN 1 stated Resident 133 did not have pain parameters with the medication orders. RN 1 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated she was not sure how other nurses are deciding what medication to administer to residents without pain parameters in the order. RN 1 stated, I think we should have pain parameters for the pain medications orders. During an interview on 4/10/26 at 11:20 a.m. with the DON, the DON stated, She [Resident 133] was alert and oriented and able to tell the licensed nurses what pain medication she wanted. The DON stated licensed nurses monitors pain every shift and nurses decides which medication to administer based on resident's complain of pain. The DON stated the facility did not add pain parameters with the pain medication orders. During a review of facility's policy and procedure (P&P) titled, Pain Assessment and Management, revision date 4/25, the P&P indicated, .Review the medication administration record to determine how often the individual requests and receives PRN pain medication, and to what extent the administered medications relieve the resident's pain .Administering medications around the clock rather than PRN . Ongoing communication between the prescriber and the staff is necessary for the optimal and judicial use of pain medications . Contact the provider immediately if the resident's pain or medication side effects are not adequately controlled .

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	055410	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brighton Post Acute	361 E. Grangeville Blvd Hanford, CA 93230

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet the needs of residents in accordance with established national guidelines for three of 49 sampled residents (Residents 41, 53 and 95) when Residents 41, 53 and 95 were not served cornbread with lunch on 4/8/26 and the menu indicated cornbread to be served.These failures resulted in Residents 41, 53 and 95 not receiving all the nutrition and calories for lunch and the potential for unintended weight loss.Findings: During an observation on 4/8/26 at 11:14 a.m. with [NAME] (CK) 1, in the kitchen, CK 1 was preparing to plate lunch for the residents in the facility. CK 1 put ham, beans and steamed cabbage on the first plate. CK 1 placed ham, beans and steamed cabbage on the second plate. CK 1 placed ham, beans and cabbage on the third plate. There was a pan of squared cornbread on the food counter next to the food items that were kept warm. During a concurrent observation and interview on 4/8/26 at 11:57 a.m. with Resident 53 in the dining room, Resident 53 was served a plate of ham, beans and steamed cabbage. Resident 53 stated she did not receive cornbread for lunch. During a concurrent observation and interview on 4/8/26 at 11:58 a.m. with Resident 41 in the dining room, Resident 41 was served a plate of ham, beans and steamed cabbage. Resident 41 stated she had not received cornbread with her lunch. During a concurrent observation and interview on 4/8/26 at 11:59 a.m. with Resident 95 in the dining room, Resident 95 eating ham off her plate. Resident 95's plate had ham, beans and steamed cabbage which she had already started eating. Resident 95 stated she had not eaten or received any cornbread for lunch. During an interview on 4/8/26 at 1:02 p.m. with [NAME] (CK) 1, CK 1 stated he missed adding cornbread at the beginning of lunch. CK 1 stated he thought he forgot about it when plating started for lunch. The CK 1 stated it was important for the Residents to get all the food items on the menu for nutrition and so they don't experience weight loss. During an interview on 4/9/26 at 2:33 p.m. with the Certified Dietary Manager (CDM), the CDM stated her expectation was that cooks follow the menu. The CDM stated it was important that the residents had the correct amount of carbohydrate, protein, etcetera to keep them healthy. The CDM stated when the menu was not followed residents could lose weight unintentionally. During an interview on 4/10/26 at 8:51 a.m. with the Registered Dietician (RD), the RD stated her expectation was that residents be served all items on the menu, unless ordered by a doctor not to have it or the residents preferences indicated they did not want the food item. The RD stated it was important to get the full menu because each item was part of the nutrient content and it was important to get all of the nutrients. The RD stated if residents did not receive all items on the menu it could lead to weight loss. During an interview on 4/10/26 at 10:03 a.m. with the Director of Nursing (DON) the DON stated all items on the menu should have been served to Residents 41,53 and 95. The DON stated the facility menu's were based on nutritional values for each day. The DON stated there was potential for (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to lose weight if they were not served all items on the menu. During a review of the facility's menu titled WEEK 1 WINTER 2025 dated 4/5/26, the menu indicated, WEDNESDAY {4/8/26] . NOON . BAKED HAM SEASONED WHITE PEAS STEAMED CABBAGE CORNBREAD/[NAME] [margarine] . During a review of Resident 41's admission Record (AR) dated 4/10/26, the AR indicated, Resident 41 was admitted to the facility on [DATE]. During a review of Resident 41's Order Summary Report (OSR) dated 4/10/26, the OSR indicated, Resident 41 had a diet order of regular diet. During a review of Resident 41's Minimum Data Set (MDS- a federally mandated process for clinical assessment of all residents of long term care nursing facilities) dated 3/18/26, the MDS indicated, Resident 41 had a Brief Interview for Mental Status (BIMS - an assessment of a resident's cognitive status; the ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life, a score of 0 – 7 indicated severe impairment, 8 – 12 indicated moderate impairment, and 13 – 15 indicated minimal to no impairment) score of 3. During a review of Resident 53's AR dated 4/10/26, the AR indicated, Resident 53 was admitted to the facility on [DATE]. During a review of Resident 53's OSR dated 4/10/26, the OSR indicated, Resident 53 had a diet order of regular diet. During a review of Resident 53's MDS dated 3/13/26, the MDS indicated, Resident 53 had a BIMS score of 14. During a review of Resident 95's AR dated 4/10/26, the AR indicated, Resident 95 was admitted to the facility on [DATE]. During a review of Resident 95's Order Summary Report (OSR) dated 4/10/26, the OSR indicated, Resident 95 had a diet order of regular diet. During a review of Resident 95's MDS dated 3/30/26, the MDS indicated, Resident 95 had a BIMS score of 8. During a review of the facility's policy and procedure (P&P) titled Food and Nutrition Services dated 2017, the P&P indicated, . Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food preferences were followed for one of eight sampled residents (Resident 33) when he was served cabbage and the resident's care plan stated resident disliked cabbage. This failure violated Resident 33's food preference and had the potential to result in weight loss.Findings: During a concurrent observation and interview on 4/8/26 at 4:11 p.m. with Resident 33 in his room. Resident 33 stated, . - I did not enjoy my lunch, the cabbage was soggy, the beans had no flavor, I only ate the ham, and I am ready to eat again but I will wait for dinner .During a review of Resident 33's admission record (AR), dated 4/9/26, the AR indicated Resident 33 was admitted to the facility on [DATE] with the following diagnosis: Hemiplegia (a form of paralysis that causes severe or complete loss of movement on one side of the body) to the right side of the body, major depressive disorder (a mental health condition characterized by persistent, intense feelings of sadness, worthlessness, and a loss of interest in activities that lasts for at least two weeks), and chronic kidney disease. During a review of Resident 33's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs), assessment dated [DATE], the MDS assessment indicated, Resident 33's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 0 to 15 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 12 out of 15 which indicated Resident 33 had moderate cognitive deficits. During a concurrent interview and record review on 4/9/26 at 9:30 a.m. with the Certified Dietary Manager (CDM), Resident 33's care plan (CP), dated 4/9/26, was reviewed. The CP indicated, . no liver, no spinach, no cabbage . The CDM stated, . Resident 33 should not have been served cabbage, it was listed on his care plan as a dislike . During an interview on 4/10/26 at 9:05 a.m. with the Registered Dietitian (RD), the RD stated, . residents should be served all items on the menu unless it is listed as a dislike on their preferences . it is important for the residents to get all of their nutrients . During an interview on 4/10/26 at 11:10 a.m. with the Director of Nurses (DON), the DON stated, . Resident 33's food preferences should have been followed, giving residents food that is on their dislike list could cause them to not eat the food resulting in unintended weight loss .During a review of the facility's policy and procedure titled, Resident Food Preferences dated 07/2017, indicated, Nursing staff will document the resident's food and eating preferences in the care plan.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed store and prepare food in accordance with professional standard for food service safety for 49 residents who were served food from the ice machine and kitchen when there was no air gap (a safety feature that uses open air to physically separate a clean water line from a dirty drain line) at the ice machine drain and no air gap at the drain of food preparation sink.These failures had the potential to result in contamination of ice and food and could lead to illnesses.Findings: During a concurrent observation and interview on 4/7/26 at 8:25 a.m. during the initial tour in the kitchen, with the Certified Dietary Manager (CDM), the food preparation sink had black pipes that went into the wall. There was a drain sink under and to the left of the food preparation sink that was not being used. The black pipe under the sink had a white plastic piece on top of the black pipe. The CDM stated the white plastic piece was an air gap installed by the maintenance department.During a concurrent observation and interview on 4/9/26 at 8:07 a.m. with the Maintenance Director (MD) in the hallway across from the kitchen, the facility's ice machine had two pipes going from the ice machine to the drain on the floor. One of the ice machine pipes was inserted into the drain, going beyond the level of the floor. The MD stated the hopper pipe from the ice machine was going past the lip of the sink drain. The MD stated the ice machines drain did not have an air gap.During a concurrent observation and interview on 4/9/26 at 8:15 a.m. with the MD, in the kitchen, the food preparation sink was observed with the white plastic piece connected to the black pipe coming from the sink. The MD stated the white plastic piece on top of the black pipe was an air gap for garbage disposal and was installed by him.During an interview on 4/9/26 at 4:04 p.m. with the MD, the MD stated it was important to have an air gap at the facility's ice machine to prevent back flow into the ice machine. The MD stated he installed an inline air gap on the pipe under the food preparation sink. The MD stated he chose an inline gap after using google to search for one. The MD stated he chose the inline gap because it went along with the exiting plumbing so he would not need to change all of it. The MD stated he did not look up regulations or food code before installing the inline air gap. The MD stated it was important to have an air gap so anyone could see if there was flooding from the outside of the facility to the inside. The MD stated backflow from the drain could contaminate the food and cause food poisoning to the residents.During an interview on 4/10/26 at 10:51 a.m. with the Administrator (ADM), the ADM stated, he was aware that an air gap pertained to drains. The ADM stated one of the pipes from the ice machine was inside of the drain. The ADM stated there should have been an air gap for the ice machine drain. The ADM stated the facility should follow the regulations for an air gap at the food preparation sink in the kitchen.During a professional reference review retrieved from https://epubs.iapmo.org/2025/CPC/ , titled CALIFORNIA 2025 PLUMBING CODE CALIFORNIA CODE OF REGULATIONS, dated 2025, effective 1/1/2026, indicated, . This chapter shall govern the materials, design, and installation of indirect waste piping, receptors, and connections; And provisions for discharge and disposal of condensate beasts, chemical wastes, industrial waste, and clear water waste . Air Gap or Air Brake Required. Indirect waste piping shall discharge into the building drainage system through an air gap or air brake as set forth in this code. Where a drainage air gap is required by this code, the minimum vertical distance as measured from the lowest point of the indirect waste pipe or the fixture outlet to the flood level rim of the receptor shall be not less than one inch . Food and Beverage Handling Establishments. Establishments engaged in the storage, preparation, selling, serving, processing, or other handling of food and beverage involving the following equipment that requires drainage shall provide indirect waste piping . ice making machines . Food-Handling Fixtures. Food-preparation sinks . shall be indirectly connected to the drainage system by means of an air gap. Wings, sinks, and other equipment having drainage connections and used for the storage of unpacking ice used for human ingestion or used in direct contact with ready to eat food, shall be indirectly connected to the drainage system by means of an (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	air gap. Each indirect waste pipe from food handling fixtures or equipment shall be separately piped into the indirect waste receptor and shall not combine with other indirect waste pipes. The piping from the equipment to the receptor shall not be less than the drain on the unit and in no cases less than 1/2 [half] of an inch .During a review of the facility's policy and procedure (P&P) titled AIR GAP FOR DRAINS AND SINKS (undated), the P&P indicated, . All sinks, drains and equipment that discharge into the plumbing system shall maintain a proper air gap when required to prevent contamination of clean water, food areas, and equipment . Drain pipes must not be placed directly into a sewer or floor drain without the proper gap . Maintenance will routinely check sinks, drains, and related equipment . Any missing air gap, drainage problem, leak, or backup must be reported immediately .

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have an effective pest control program to ensure the facility was free of pests for 51 residents that ate food prepared in the kitchen when two flies were in the kitchen on 4/7/26 and one fly was in the kitchen on 4/8/26.These failures had the potential for cross-contamination (the transfer of harmful germs from one surface to another) from the flies to resident food which could result in illnesses.Findings:During an observation on 4/7/26 at 8:35 a.m. during the initial tour in the kitchen, two flying insects were observed flying around the dishwashing area.During an interview on 4/8/26 at 9:18 a.m. with Dietary Aid (DA) 1, DA 1 stated there had not been a problem with flies in the kitchen until today. DA 1 stated the kitchen had a negative airflow over the exit door to assist with the control of flies. DA 1 stated it was important not to have flies in the kitchen because of cross contamination. DA 1 stated if there was a problem with flies in the kitchen, we would notify the Certified Dietary Manager (CDM).During an interview on 4/8/26 at 9:36 a.m. with the CDM the CDM stated, if flies were found in the kitchen, kitchen staff would alert her and then she would alert the maintenance department.During an observation on 4/8/26 at 11:37 a.m. in the kitchen, [NAME] (CK) 1 was preparing lunch for the residents. One flying insect was observed on top of a section of a wood countertop over by the food possessor. The flying insect then flew around the food being prepared and landed on the metal tongs that sat atop of a pan of corn bread. During a review of the facility's menu titled WEEK 1 WINTER 2025 dated 4/5/26, the menu indicated, WEDNESDAY [4/8/26] . NOON . CORNBREAD/[NAME] [margarine] .During an interview on 4/9/26 at 2:28 p.m. with the CDM, the CDM stated she observed two flies in the kitchen on 4/7/26 and one fly in the kitchen on 4/8/26. The CDM stated the insect over by the food processor and on the metal tongs appeared to be a fly. The CDM stated her expectation was that the kitchen had no flies. The CDM stated flies could cause cross contamination when the flies carry bacteria from their feet to the residents food. The CDM stated when there were files present in the kitchen there was a possibility that the residents could get sick.During an interview on 4/10/26 at 9:46 a.m. with the Director of Nursing (DON), the DON stated her expectation was that the facility did not have flies in the kitchen. The DON stated there was a risk of foodborne illness (an infection or irritation of the digestive tracts caused by consuming food containing germs) and contamination of the food when flies were in the kitchen. The DON stated there was a potential for residents at the facility to become ill when flies were in the kitchen.During a review of the facility's maintenance request log titled REQUEST ORDERS (RO) (undated), the RO indicated, . DATE . 4/6 [4/6/26] . PROBLEM . Flies in the building .During a review of the facility's policy and procedure (P&P) titled Pest Control Program (undated), the P&P indicated, .The facility will maintain a clean, safe environment and take prompt action to keep the building free of insects, rodents, and other pests . All sightings , reports, treatments, and follow-up actions will be documented and maintained for compliance review .