STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055475	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main West Postacute Care	812 West Main Street Turlock, CA 95380

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 28193 Based on interview, record review, and facility policy review, the facility failed to ensure staff reported a resident's grievance to the designated Grievance Officer so that an investigation could be initiated for 1 (Resident #66) of 21 sampled residents. Findings included: A facility policy titled, Grievances/Complaints, Recording & Investigating, dated 01/2018, revealed, All grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Policy Interpretation and Implementation 1. The Administrator has assigned the responsibility of investigating grievances and complaints to the Social Services Department if applicable, otherwise, 2. 2. Upon receiving a grievance and complaint report, designated Grievance Officer will begin an investigation into the allegation. 3. The Department Director(s) of any named employee(s) will be notified of the nature of the complaint that an investigation is underway. 4. The investigation and report will include, as applicable: a. the date and time of the alleged incident; b. the circumstances surrounding the alleged incident; c. the location of the alleged incident; d. the names of any witnesses and their accounts of the alleged incident; e. the resident's account of the alleged incident; f. the employees account of the alleged incident; g. Accounts of any other individuals involved (i.e. employee's supervisor, etc.); and h. recommendations for corrective action. An Admission Record revealed the facility admitted Resident #66 on 05/03/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of pneumonia. A 5-Day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/04/2024, revealed Resident #66 had a Brief Interview for Mental Status score of 14, which indicated the resident had intact cognition. The MDS indicated the resident was dependent on staff for all activities of daily living (ADLs) and had moderately impaired vision. During an interview on 03/03/2025 at 9:47 AM, Resident #66 stated the staff were eating their candy bars. According to Resident #66, when the staff gave them a candy bar, the staff either took some for themselves or took the candy bar at night when they were asleep, without their permission. Resident #66 stated they were completely out of their candy bar and they thought a male nurse took them. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Main West Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 812 West Main Street Turlock, CA 95380	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/04/2025 at 2:10 PM, Certified Nurse Assistant (CNA) #1 stated she did not remember the day, but either 02/27/2025 or 02/28/2025, Resident #66 told her that they were missing chocolate candy bars out of their snack drawer. CNA #1 stated she reported to a nurse that Resident #66's chocolate candy bars were not in the resident's snack drawer. According to CNA #1, either on 02/27/2025 or 02/28/2025, when the resident asked for a chocolate candy bar, there were four in the resident's snack drawer and she gave the resident two. CNA #1 stated when the resident asked for a chocolate candy bar on 03/04/2025, there were none in the snack drawer. CNA #1 stated she only reported the resident's missing chocolate candy bars to the nurse. During an interview on 03/04/2025 at 2:17 PM, Licensed Vocational Nurse (LVN) #2 stated Resident #66 told him they were missing chocolates and that he tried to help find the chocolate candy bars, but they were not in the resident's snack drawer. LVN #2 stated he thought he might have talked with the resident's family, but did not remember when. According to LVN #2, the resident's family visited the resident on 03/04/2025 and brought some more chocolate candy bars for Resident #66. LVN #2 acknowledged he did not do anything else about the resident's missing chocolate candy bars because the resident's family brought more to the resident. LVN #2 stated he did not notify anyone of the resident's missing chocolate candy bars. During an interview on 03/05/2025 at 3:47 PM, the Interim Social Services Director (SSD) stated the grievance process was when a resident complained, they did an investigation on how it happened and tried to produce a solution within 48 hours. The Interim SSD stated she expected staff to have notes on what was told to them with the time and a complete description of what happened, and for them to tell her as soon as possible. The Interim SSD stated she had not received any grievances recently regarding missing candy for Resident #66. During an interview on 03/07/2025 at 8:40 PM, the Director of Nursing (DON) stated her expectation was if anyone voiced a grievance, a grievance form was to be filled out right away and the charge nurse was to be notified so the facility could follow the policy going forward and address the issue at hand. During an interview on 03/07/2025 at 9:57 AM, the Administrator stated he expected staff to follow the grievance process.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 52274 Based on interview, record review, document review, and facility policy review, the facility failed to report allegations of abuse to facility management and to the state survey agency for 2 (Resident #57 and Resident #69) of 3 sampled residents reviewed for abuse. Specifically, facility staff failed to report allegations of abuse after becoming aware of the allegation when a police officer reported to staff that Resident #57 called and said a staff member restrained the resident; and when a police officer reported to staff that Resident #69 called and reported that a certified nursing assistant (CNA) pushed them. Findings included: A facility policy titled, Abuse and Neglect Prohibition Policy, dated 06/2022, revealed, It is the facility's policy to prohibit abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property for all residents through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Reporting of incidents, investigations, and the facility's response to the results of their investigations; The policy continued, 1. Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect or exploitation the Administrator or designee will perform the following: i. All alleged violations-Immediately but not later than: 1. 2 hours-if the alleged violation involves abuse or results in serious bodily injury. 1. An Admission Record indicated the facility admitted Resident #57 on 01/24/2025. According to the Admission Record, the resident had a medical history that included diagnoses of insomnia, and depression. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/28/2025, revealed Resident #57 had a Brief Interview For Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #57's Care Plan Report, included a focus area initiated 01/28/2025, that indicated the resident had a history of traumatic events related to being physically and/or emotionally abused. Interventions directed staff to assess for possible triggers related to said trauma, create a trauma-sensitive environment, and encourage the resident to inform staff when they are uncomfortable with staff or resident interaction. The Care Plan Report also included a focus area initiated 01/28/2025, that indicated the resident had behaviors that included getting upset when not getting attention and getting verbally aggressive when they did not get their own way. Interventions directed staff to encourage the resident to appropriately express all feelings and concerns, listen attentively, and attempt to resolve all areas and conflict and to monitor the resident for fabricating stories. A nursing Progress Note, dated 03/03/2025 at 7:00 AM, indicated that at around 7:00 AM, a police officer came to the facility and informed the nurse that Resident #57 called 911 and stated one of the workers was restraining them. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 1:41 PM, Resident #57 stated they made a call to the police on 03/03/2025 and the police came to the facility. The resident stated during the night a staff person grabbed them from behind and threw them down on the bed. During an interview on 03/03/2025 at 3:05 PM, the Administrator stated he was not aware of any allegations of abuse in the last 24 hours. The Administrator stated he was the Abuse Coordinator. He stated any allegations of abuse should have been reported to him right away, and that he was not aware of an incident with Resident #57. The Administrator stated the allegation of abuse should have been reported within two hours. During an interview on 03/03/2025 at 3:14 PM, the Director of Nursing (DON) stated if a CNA or a nurse were aware of an allegation of abuse they should report the allegation of abuse to the Administrator. During an interview on 03/05/2025 at 2:09 PM, Registered Nurse (RN) #9 stated they were Resident #57's charge nurse on the date of the incident. RN #9 stated the police entered the facility and spoke to Resident #57, then spoke to her. RN #9 stated the police reported to her that Resident #57 called the police and stated they were held from the back by a staff person. RN #9 stated she was aware of care that was provided to the resident's roommate but was not aware of any abuse. RN #9 stated she told the DON about the residents' behavior after 9:00 AM on 03/03/2025. During a follow-up interview on 03/07/2025 at 10:45 AM, the DON stated herself and the Abuse Coordinator should have been notified right away of the incident and she was not sure why staff had not notified administration. During a follow-up interview on 03/07/2025 at 11:18 AM, the Administrator stated his expectation was for allegations of abuse to be reported. He stated when police came into the building, staff were to notify the supervisor and the Administrator. The Administrator stated staff should have notified the DON and himself right away. 2. An Admission Record indicated the facility admitted Resident #69 on 11/09/2023. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive sleep apnea, major depressive disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/2024, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #69's Care Plan Report, included a focus area initiated 12/03/2024, that indicated the resident had insomnia. Interventions directed staff to provide a quiet environment during sleep hours. The Care Plan Report also included a focus area initiated 01/21/2025, that indicated the resident became upset when staff went into their room to care for their roommate, especially at night, threw stuff at staff when upset, fabricated stories about staff and residents to get their way, and told visitors things about the facility staff and residents that were false. Interventions directed staff to educate the resident about staff needing to come into their room to tend to other residents. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/03/2025 at 1:44 PM, Resident #69 stated that staff attacked them and threw them against the wall about one month ago. Resident #69 stated they reported it, the police came to the facility, and that the facility staff investigated the incident. During an interview on 03/05/2025 at 4:30 PM, Resident #69 stated they called the police officer the day after the incident. Resident #69 stated they did not report the incident to anyone at the facility. Resident #69 stated they were not sure if the male staff still worked at the facility because they had not seen the staff since the incident. An investigation packet provided by the facility included an undated typed document, signed by the Director of Nursing (DON) that revealed a paragraph that indicated that on 01/20/2025 around 10:45 PM, a certified nursing assistant (CNA) reported Resident #69 was assisted to the floor. The document indicated in a separate paragraph that around 3:00 PM, a police officer was called to the facility by Resident #69, who reported that a CNA pushed the resident the prior night. There was no evidence included in the facility's investigation packet that the allegation of abuse was reported to the Administrator or to the state agency. During an interview on 03/05/2025 at 5:01 PM, the Administrator stated Resident #69 stated that a staff pushed them down, but per the staff that did not happen, but instead the staff rushed to brace the resident's fall. During a follow-up interview on 03/05/2025 at 5:08 PM, the Administrator stated that the state agency was not notified of the allegation because it was not abuse per interviews with the staff.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52274 Based on interview, record review, document review, and facility policy review, the facility failed to identify and thoroughly investigate an allegation of abuse for 1 (Resident #69) of 3 sampled residents reviewed for abuse. Specifically, facility staff failed to investigate an allegation of abuse for Resident #69 once they became aware of the allegation when a police officer came to the facility on [DATE] and reported to staff that Resident #69 called and reported that a certified nursing assistant (CNA) pushed them. Findings included: A facility policy titled, Abuse and Neglect Prohibition Policy, dated 06/2022, revealed, It is the facility's policy to prohibit abuse, mistreatment, neglect, involuntary seclusion, and misappropriation of property for all residents through the following: Screening of potential hires; Training of employees (both new employees and ongoing training for all employees); Prevention of occurrences; Identification of possible incidents or allegations which need investigation; Investigation of incidents and allegations; Reporting of incidents, investigations, and the facility's response to the results of their investigations; The policy continued, 5. When an abuse is identified, the appropriate steps to protect residents from additional abuse will be implemented immediately, which will include: i. Conducting a thorough investigation of the alleged abuse. An Admission Record indicated the facility admitted Resident #69 on 11/09/2023. According to the Admission Record, the resident had a medical history that included diagnoses of obstructive sleep apnea, major depressive disorder, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/15/2024, revealed Resident #69 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #69's Care Plan Report, included a focus area initiated 12/03/2024, that indicated the resident had insomnia. Interventions directed staff to provide a quiet environment during sleep hours. The Care Plan Report also included a focus area initiated 01/21/2025, that indicated the resident became upset when staff went into their room to care for their roommate, especially at night, threw stuff at staff when upset, fabricated stories about staff and residents to get their way, and told visitors things about the facility staff and residents that were false. Interventions directed staff to educate the resident about staff needing to come into their room to tend to other residents. During an interview on 03/03/2025 at 1:44 PM, Resident #69 stated that staff attacked them and threw them against the wall about one month ago. Resident #69 stated they reported it, the police came to the facility, and that the facility staff investigated the incident. During an interview on 03/05/2025 at 4:30 PM, Resident #69 stated they called the police officer the day after the incident. Resident #69 stated they did not report the incident to anyone at the facility. Resident #69 stated they were not sure if the male staff still worked at the facility because they had not seen the staff since the incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An investigation packet provided by the facility included an undated typed document, signed by the Director of Nursing (DON) that revealed a paragraph that indicated that on 01/20/2025 around 10:45 PM, a certified nursing assistant (CNA) reported Resident #69 was assisted to the floor. The document indicated in a separate paragraph that around 3:00 PM, a police officer was called to the facility by Resident #69, who reported that a CNA pushed the resident the prior night. There was no evidence included in the facility's investigation packet that the allegation of abuse was reported to the Administrator or to the state agency. During an interview on 03/07/2025 at 10:45 AM, the DON stated for abuse allegations investigations should begin right away and the staff member should be suspended until the investigation was completed. The DON stated that interviews of the staff that were present during the time of the incident should be conducted, to include the supervisor, the resident involved, and any other alert and oriented residents who witnessed the incident. During an interview on 03/05/2025 at 5:01 PM, the Administrator stated Resident #69 stated that staff pushed them down, but per the staff that did not happen, but instead the staff rushed to brace the resident's fall. During a follow-up interview on 03/07/2025 at 11:18 AM, the Administrator stated that his expectation was for allegations of abuse to be reported.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, record review, document review, and facility policy review, the facility failed to complete a comprehensive assessment at least every 366 days for 4 (Residents #9, #23, #66, and #89) of 22 sampled residents reviewed for resident assessment. Findings included: A facility policy titled, MDS [Minimum Data Set] Completion and Submission Timeframes, dated 01/2018, revealed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy specified, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual, dated 10/2024, revealed Comprehensive Assessments OBRA [Omnibus Budget Reconciliation Act]-required comprehensive assessments include the completion of both the MDS and the CAA [care area assessment] process, as well as care planning. Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred or a significant correction to a prior comprehensive assessment is required. They consist of: *Admission Assessment *Annual Assessment *Significant Change in Status Assessment [[NAME]] *Significant Correction to Prior Completion Assessment [SCPA]. Per the User's Manual, The Annual assessment is a comprehensive assessment for a resident that must be completed on an annual basis (at least every 366 days) unless a SCSA or an SCPA has been completed since the most recent comprehensive assessment was completed. 1. An Admission Record revealed the facility admitted Resident #89 on 01/13/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of dementia. Resident #89's medical record revealed the last comprehensive MDS was an admission MDS with a date of 01/20/2024. There was no evidence to indicate another comprehensive assessment was completed after 01/20/2024. 49044 2. An Admission Record revealed the facility admitted Resident #9 on 01/12/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease. Resident #9's medical record revealed the last comprehensive MDS was an annual MDS with a date of 01/19/2024. There was no evidence to indicate another comprehensive assessment was completed after 01/19/2024. 3. An Admission Record revealed the facility admitted Resident #23 on 03/21/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of metabolic encephalopathy. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #23's medical record revealed the last comprehensive MDS was a significant change in status MDS with a date of 01/22/2024. There was no evidence to indicate another comprehensive assessment was completed after 01/22/2024. 28193 4. An Admission Record revealed the facility admitted Resident #66 on 05/03/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of pneumonia. Resident #66's medical record revealed no evidence to indicate an admission MDS had been completed. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated her first day of employment with the facility was 01/27/2025. The MDS Nurse stated when she started, she knew there were a lot of MDS assessments that were either late or not done. Per the MDS Nurse, the plan going forward was for her to catch up on the incomplete assessments, but there was a lot to do. The MDS Nurse stated Resident #9 and Resident #23 were overdue for an annual MDS, the last quarterly MDS for Resident #89 in 01/2025 should have been an annual MDS, and an admission MDS should have been done for Resident #66 in 11/2024. During an interview on 03/06/2025 at 2:48 PM, the Director of Nursing stated she was not aware there were MDS assessments that had not been completed. During an interview on 03/07/2025 at 9:32 AM, the Administrator stated the expectation for the staff was to follow the RAI Manual and complete the MDS assessment timely.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35314 Based on interview, record review, document review, and facility policy review, the facility failed to complete a quarterly Minimum Data Set (MDS) at least every 92 days for 3 (Residents #24, #66, and #93) of 22 sampled residents reviewed for resident assessment. Findings included: A facility policy titled, MDS [Minimum Data Set] Completion and Submission Timeframes, dated 01/2018, revealed, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy specified, 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3. 0 User's Manual, dated 10/2024, revealed The Quarterly assessment is an OBRA [Omnibus Budget Reconciliation Act] non-comprehensive assessment for a resident that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. Per the User's Manual, The MDS completion date must be no later than 14 days after the ARD [assessment reference date]. 1. An Admission Record revealed the facility admitted Resident #24 on 10/28/2011. According to the Admission Record, the resident had a medical history that included a diagnosis of dementia. Resident #24's medical record revealed the last comprehensive MDS was an annual MDS dated [DATE]. There was no evidence to indicate a quarterly MDS assessment was completed in 01/2025. 28193 2. An Admission Record revealed the facility admitted Resident #66 on 05/03/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of pneumonia. Resident #66's medical record revealed the last MDS was a quarterly MDS dated [DATE]. There was no evidence to indicate a quarterly MDS assessment was completed in 01/2025. 49044 3. An Admission Record revealed the facility admitted Resident #93 on 10/22/2024. According to the Admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. Resident #93's medical record revealed an admission MDS dated [DATE]. Further review revealed, a quarterly MDS with an Assessment Reference Date (ARD) of 01/26/2025, revealed the MDS was signed as being completed by the Director of Nursing (DON) on 03/04/2025. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated her first day of employment with the facility was 01/27/2025. The MDS Nurse stated when she started, she knew there were a lot of MDS assessments that were either late or not done. Per the MDS Nurse, the plan going forward was for her to catch up on the incomplete assessments, but there was a lot to do. The MDS Nurse stated Resident #24 was overdue for a quarterly MDS and a quarterly MDS had not yet been started for Resident #66. During an interview on 03/06/2025 at 2:48 PM, the DON stated she was not aware there were MDS assessments that had not been completed. During an interview on 03/07/2025 at 9:32 AM, the Administrator stated the expectation for the staff was to follow the RAI Manual and complete the MDS assessment timely.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 28193 7. Resident #31's electronic medical record revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/23/2025 had a status of Export Ready. The screen did not indicate the assessment completion date. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated Resident #31's quarterly MDS with an ARD of 01/23/2025 was completed on 02/06/2025 and was not submitted until 03/04/2025 (26 days after the assessment completion date). She stated the status of export ready meant the assessment was locked and ready to be submitted but had not yet been sent over or transmitted to CMS. 8. Resident #79's electronic medical record revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/10/2025 had a status of Export Ready. The screen did not indicate the assessment completion date. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated Resident #79's quarterly MDS with an ARD of 01/10/2025 was completed on 01/24/2025 but was not submitted until 03/04/2025 (39 days after the assessment completion date). She stated the status of export ready meant the assessment was locked and ready to be submitted but had not yet been sent over or transmitted to CMS. 9. Resident #88's MDS transmission revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/17/2025 had a status of Export Ready. The screen did not indicate the assessment completion date. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated Resident #88's quarterly MDS with an ARD of 01/17/2025 was completed on 02/12/2025 but was not submitted/accepted until 03/04/2025 (20 days after the assessment completion date. She stated the status of export ready meant the assessment was locked and ready to be submitted but had not yet been sent over or transmitted to CMS. During the interview on 03/06/2025 at 9:38 AM, the MDS Nurse discussed her experience, training, and process with the facility's MDS assessments. She stated she had been working at the facility since 01/27/2025. She indicated she was aware there were a lot of MDSs that were late or not completed and had been told it was due to gaps in MDS Coordinators. The MDS Nurse stated she was receiving her training from the corporate office and Directors of Nursing and MDS Coordinators from other facilities, all while trying to create and maintain a current MDS schedule going forward. She stated she had been trying to work on the late or incomplete assessments little by little while doing the assessments that were currently due. For scheduling of the MDSs and to know what type of MDS to complete next, she stated she was relying on the facility's electronic medical record software to guide her. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	During an interview on 03/06/2025 at 2:48 PM, the Director of Nursing (DON) stated she had been employed as the DON since 11/16/2024. She stated when she became the DON, there was a registered nurse (RN) in the role of MDS Coordinator who locked and submitted her own assessments. The new MDS Nurse was a licensed vocational nurse (LVN), so when she was finished with the assessments, she asked the DON to sign and lock them for her. The DON stated she was not made aware of any MDSs that were not complete or not sent in. She stated the prior MDS Coordinator left in January of 2025, and the new MDS Nurse started at the end of January 2025. She stated she was notified just the previous week that she would need to sign and lock the MDSs going forward; however, she was not made aware that she needed to sign assessments that were completed prior to the new MDS person starting. The DON stated she was new to the process and was learning with the new person what to do. She could not state how to check which MDSs were due or which MDSs needed to be completed. She stated the MDS Nurse was still new and was still learning, but her expectation was that the facility stay up to date with the MDS assessments. During an interview on 03/07/2025 at 9:32 AM, the Administrator stated he had started with the company in November of 2023. He stated his expectation was for the MDS to be transmitted timely within 14 days. He indicated the facility should follow the MDS schedule and the RAI Manual. 35314 Based on record review, interview, facility policy review, and review of the Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual, the facility failed to ensure Minimum Data Set (MDS) assessments were transmitted to the Centers for Medicare and (&) Medicaid Services (CMS) system within 14 days after the assessments were completed for 9 (Residents #15, #31, #33, #41, #55, #60, #71, #79, and #88) of 22 sampled residents reviewed for resident assessment. Findings included: A facility policy titled, MDS Completion and Submission Timeframes, released 01/2018, indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes. The policy also specified, 1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS' QiES [Internet Quality Improvement and Evaluation System] Assessment Submission and Processing (ASAP) System in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual (RAI). The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, effective 10/2024, indicated, The MDS must be transmitted (submitted and accepted into iQIES) electronically no later than 14 calendar days after the MDS completion date [Item #] (Z0500B + 14 calendar days). 1. Resident #41's electronic medical record Minimum Data Set (MDS 3.0) Summary screen revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/17/2025 was completed on 01/31/2025 but was not transmitted and accepted until 03/04/2025 (33 days after completion). During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse confirmed that Resident #41's MDS was completed on 01/31/2025 and locked/accepted by CMS on 03/04/2025. (continued on next page)

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	2. Resident #55's electronic medical record Minimum Data Set (MDS 3.0) Summary screen revealed a quarterly MDS with an ARD of 01/24/2025 was completed on 02/07/2025 but was not transmitted and accepted until 03/04/2024 (26 days after completion). During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse confirmed that Resident #55's MDS was completed on 02/07/2025 and locked/accepted on 03/04/2025. 49044 3. Resident #60's electronic medical record Assessment History screen revealed a quarterly MDS with an Assessment Reference Date of 01/25/2025 was accepted on 03/04/2025 (39 days after the assessment date). The screen did not indicate the completion date. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated for Resident #60, the quarterly MDS with an ARD of 01/25/2025 was completed on 02/08/2025 and was locked/accepted on 03/04/2025 (24 days after the assessment was completed). 52274 4. Resident #19's electronic medical record Minimum Data Set (MDS 3.0) Summary screen revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/22/2025 was completed on 02/05/2025 but was not locked and accepted by the CMS System until 03/04/2025 (27 days after the assessment completion date). During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse confirmed Resident #18's quarterly MDS with an ARD of 01/22/2025 was completed on 02/05/2025 and not locked/accepted by CMS until 03/04/2025. 5. Resident #35's electronic medical record Minimum Data Set (MDS 3.0) Summary screen revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/23/2025 was completed on 02/06/2025 but was not locked/accepted by the CMS System until 03/04/2025 (26 days after the assessment completion date). During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse confirmed Resident #35's quarterly MDS with an ARD of 01/23/2025 was completed on 02/06/2025 but was not locked/accepted by CMS until 03/04/2025. 6. Resident #49's electronic medical record Minimum Data Set (MDS 3.0) Summary screen revealed a quarterly MDS with an Assessment Reference Date (ARD) of 01/21/2025 was completed on 02/04/2025 but was not locked and accepted by the CMS System until 03/04/2025 (28 days after the assessment completion date). During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated Resident #49's quarterly MDS with an ARD of 01/21/2025 was completed on 02/04/2025 and not locked/accepted by CMS until 03/04/2025.

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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. 28193 Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 (Resident #42) of 3 sampled residents reviewed for preadmission screening and resident review (PASARR). Findings included: A facility policy titled, Certifying Accuracy of the Resident Assessment, dated 01/2018, revealed, Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and verify the accuracy of that portion of the assessment. An Admission Record revealed the facility admitted Resident #42 on 05/03/2019. According to the Admission Record, the resident had a medical history that included diagnoses of schizophrenia and major depressive disorder. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/10/2024, revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident was not currently considered by the state level II PASARR process to have a serious mental illness and/or intellectual disability or a related condition. Per the MDS, the resident had active diagnoses to include depression and schizophrenia. Resident #42's Care Plan Report included a focus area, initiated 07/01/2021, that indicated the resident had impaired cognitive function related to diagnoses of schizophrenia and depression. During an interview on 03/06/2025 at 9:38 AM, the MDS Nurse stated she began employment with the facility on 01/27/2025 and count not speak to any MDS assessments done before 01/27/2025. During an interview on 03/06/2025 at 2:48 PM, the Director of Nursing stated she was not aware of any MDS assessment that were not accurate. During an interview on 03/07/2025 at 9:32 AM, the Administrator stated the expectation was for the MDS assessment to be accurate.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 52274 Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of a preadmission screening and resident review (PASARR) for 1 (Resident #84) of 3 sampled residents reviewed for PASARR. Findings included: A facility policy titled, Preadmission Screening and Resident Review, with a release date of 01/2018, indicated, The completed Level I screening form must be reviewed by the Admissions Coordinator or designated staff to verify completeness and accuracy. An Admission Record indicated the facility admitted Resident #84 on 03/29/2023. According to the Admission Record, the resident had a medical history to include a diagnosis of unspecified psychosis, schizophrenia, major depressive disorder, bipolar disorder, and anxiety disorder. Resident #84's Preadmission Screening and Resident Review Level I Screening, dated 08/07/2023, revealed the resident did not have a serious diagnosed mental disorder such as depressive disorder, anxiety disorder, panic disorder, schizophrenia/schizoaffective disorder, or symptoms of psychosis, delusions, and/or mood disturbance. During an interview on 03/05/2025 at 9:06 AM, the Director of Nursing (DON) stated Resident #66's PASARR dated 08/07/2023 was not filled out correctly. The DON stated the admissions person was responsible to review the PASARR for accuracy. During an on 03/07/2025 at 10:36 AM, the DON stated the expectation was that the PASARR was completed accurately. She stated she was not sure why Resident #84's PASARR was not completed accurately. During an interview on 03/07/2025 at 11:12 AM, the Administrator stated he expected the PASARR to be accurate. He stated that the person responsible should double check themself to ensure accurate completion of the PASARR. The Administrator stated there was no one at the facility at the present time to check the PASARR for accuracy.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 28193 Based on observation, interview, and record review, the facility failed to ensure licensed nurses stayed with a resident to ensure all medication was administered as ordered by the physician for 1 (Resident #8) of 21 sampled residents. Findings included: An Admission Record revealed the facility admitted Resident #8 on 09/23/2024. According to the Admission Record, the resident had a medical history that included diagnoses of chronic obstructive pulmonary disease, acute bronchitis, chronic respiratory failure, and acute respiratory failure. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/08/2025, revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #8's Care Plan Report, included a focus area initiated 08/26/2024, that indicated the resident had chronic obstructive pulmonary disease with multiple comorbidities. Interventions directed staff to administer ipratropium-albuterol inhalation solution and albuterol-ipratropium as ordered. Resident #8's Order Summary Report that contained active orders as of 03/10/2025, revealed an order dated 09/10/2024, for ipratropium-albuterol inhalation solution 0.5-2.5 milligrams (mg)/3 milliliters (ml), inhale 3 ml orally every six hours for shortness of breath related to chronic obstructive pulmonary disease with acute exacerbation. During a concurrent observation and interview on 03/04/2025 at 8:30 AM, Resident #8 was observed lying in their bed with a breathing treatment in place and aerosol vapor was observed coming from the end of the mouthpiece/mask. There was not a nurse present and Resident #8 acknowledged they was doing their breathing treatment. During a concurrent observation and interview on 03/05/2025 at 7:58 AM, Resident #8 was noted sitting on the edge of their bed. The resident's nebulizer machine was on and there was aerosol vapor coming from the mouthpiece/mask which was in the resident's mouth. Resident #8 stated they had just woken up and were taking their breathing treatment before their breakfast. The resident stated the night shift nurse left the breathing treatment for them to administer. During an interview on 03/05/2025 at 11:09 AM, Resident #8 stated the nurses put the medication in the machine for them and they took it when they woke up in the morning. During an interview on 03/07/2025 at 8:41AM, Registered Nurse (RN) #3 stated that around 5:15 AM to 5:30 AM, she placed medication in the nebulizer machine for Resident #8. She stated when the treatment was done, she would go back in the room, wipe out the mask, and put the nebulizer and tubing back into the bag to cover it. When asked about the 03/04/2025 and 03/05/2025 of the resident with the nebulizer treatment in place, RN #3 stated the resident must not have finished all the medication and then turned the machine back on themself. RN #3 stated she knew it was the nurse's responsibility to ensure a resident had taken all the medication, whether it was a pill or nebulizer treatment. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/2025 at 12:47 PM, Licensed Vocational Nurse (LVN) #4 stated she had given Resident #8 a breathing treatment at noon and had placed the medication in the cup of the mouthpiece and handed it to the resident to administer. LVN #4 stated she did not stay in the room with the resident for the entire ten to fifteen minutes until the treatment was complete. LVN #4 stated she went back a little later to see if the resident finished the treatment. During an interview on 03/07/2025 at 8:35 AM, the Director of Nursing (DON) stated she was not aware Resident #8 administered their own nebulizer treatments without the nurses present. The DON stated it was her expectation that the nurses stay with the resident when giving nebulizer treatments and to follow the policy for medication administration.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49044 Based on interview, record review, document review, and facility policy review, the facility failed to implement the pharmacist's recommendation for 1 (Resident #93) of 5 sampled residents reviewed for unnecessary medications. Findings included: An undated facility policy titled, Consultant Pharmacist Reports, revealed, The consultant pharmacist performs a comprehensive medication regimen review (MRR) at least monthly. The MRR includes evaluating the resident's response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. Findings and recommendations are reported to the director of nursing and the attending physician, and if appropriate, the medical director and/or the administrator. The policy further revealed, G. Recommendations are acted upon and documented by the facility staff and or the prescriber. 1) Physician accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. An Admission Record revealed the facility admitted Resident #93 on 10/22/2024. According to the Admission Record, the resident had a medical history to include a diagnosis of constipation. A quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 01/26/2025, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) of 15, which indicated the resident had intact cognition. Resident #93's Care Plan Report, included a focus area initiated 10/22/2024, that indicated the resident had constipation related to decreased mobility. Interventions directed staff to administer senna, polyethylene glycol and docusate sodium as prescribed. The Consultant Pharmacist's Medication Regimen Review for recommendations created between 11/17/2024 and 11/18/2024, revealed Resident #93 was currently on Colace (docusate sodium), polyethylene glycol 3350 (a laxative), and senna and Please add to the order: Hold for loose stools. The follow-through section of the Consultant Pharmacist's Medication Regimen Review for the recommendation to add to the medication order hold for loose stools had a check mark and was notated done. Resident #93's Medication Review Report, which contained medication orders on or after 03/05/2025, revealed an order dated 10/22/2024, for polyethylene glycol 3350 oral packet 17 grams, give one packet by mouth two times a day for bowel care management, mix with 4-8 ounces of water. The order did not indicate to hold the medication for loose stools. During an interview on 03/05/2025 at 3:33 PM, Licensed Vocational Nurse (LVN) #12 stated that the charge nurses did not do anything with the pharmacy reviews (recommendations). Per LVN #12, if something were needed to be done, it would be done by the registered nurse (RN) supervisor or the Director of Nursing (DON). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/05/2025 at 3:44 PM, the DON stated the charge nurses and the supervisors were in charge of following up any nursing pharmacy recommendations. During an interview on 03/07/2025 at 8:38 AM, RN #17 stated she assigned pharmacy recommendations to the night shift supervisors to complete. RN #17 stated she was familiar with Resident #93 but had not worked on any pharmacy recommendations for the resident. RN #17 stated the recommendations should be followed. According to RN #17, if the physician agreed with the recommendation, it should have been done within one to two days. During an interview on 03/07/2025 at 9:57 AM, the Administrator stated pharmacy recommendation should be followed and if it was recommended to hold a stool softener, the staff should have added it to the medication order.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. 52274 Based on observation, interview, record review, document review, and facility policy review, the facility failed to address dental needs for 1 (Resident #39) of 1 sampled resident reviewed for dental. Findings included: A facility policy titled, Availability of Services, Dental, dated 01/2018 indicated the following, Oral healthcare and dental services will be provided to each resident. PROCESS 1. Dental services are available to all residents requiring routine and emergency dental care. The policy continued, 3. Social services will be responsible for making necessary dental appointments. 4. All requests for routine and emergency dental services should be directed to social services to assure that appointments can be made in a timely manner. An Admission Record indicated the facility admitted Resident #39 on 02/15/2024. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/19/2024, revealed Resident #39 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #39's Care Plan Report, included a focus area initiated 02/22/2024, that indicated the resident had oral/dental health problems related to poor oral hygiene and the resident having missing and broken teeth. The care plan goal was for the resident to get regular dental checkups as feasible. Resident #39's Order Summary Report, with active orders as of 03/07/2025, revealed an order dated 09/27/2024, for dental consult and treatment as indicated. During a concurrent observation and interview on 03/03/2025 at 9:33 AM, Resident #39 stated they had problems with their teeth and had asked the social worker for assistance with taking care of their teeth and that it had not been done. Some of the resident's teeth were observed broken, discolored, and some were missing. Resident #39's Oral Health Care Patient Notes, dated 04/22/2024, indicated the resident had a new patient examination, an oral cancer exam, and a hard/soft tissue exam, which were all within normal limits. The Oral Health Care note indicated that bridge #9 through 11 needed to be replaced with an outside dentist. There was no evidence in Resident #39's record to indicate the recommendation for the resident's bridge to be replaced had been completed. Resident #39's Oral Health Care Patient Notes, dated 11/18/2024, indicated an intraoral examination was completed and found to be within normal limits. The Oral Health Care note had a handwritten note on the document that indicated a referral to an oral surgeon was needed for multiple extractions with an outside dentist. There was also a handwritten note that indicated x-rays would be performed at the next visit to assess if the extraction could be done in facility. There was no evidence in Resident #39's record to indicate the recommendation for the extractions had been completed. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Psychosocial Note, dated 11/26/2024 at 12:48 PM, indicated Resident #39 was seen by the facility's dental provider on 11/18/2024. The note indicated that the dental provider suggested that the resident go outpatient for extractions. The note indicated that the social worker shared that due to the resident being a gurney patient, local dental offices were unable to accommodate the resident. A Psychosocial Note, dated 02/05/2025 at 3:50 PM, indicated that Resident #39 came to visit the social worker inquiring about seeing a dental specialist, and that the social worker reached multiple barriers for the resident's dental care due to dental offices not being equipped to transfer the resident from a wheelchair to a dental medical procedure chair. The note indicated that the resident's only known option for receiving dental work was in an alternate county; however, they experienced high volume of patients and were booked for the year 2025. Resident #39's Oral Health Care, note dated 02/11/2025, indicated a recommendation for full mouth extractions. There was no evidence in Resident #39's record to indicate the recommendation for the extractions had been scheduled. During an interview on 03/04/2025 at 10:47 AM, Resident #39 stated that they were still waiting to see a dentist, they sometimes felt pain but had no pain currently. The resident stated they could not remember the date when they last had dental pain. During an interview on 03/04/2025 at 12:05 PM, the Interim Social Service Director stated that a referral had been sent for Resident #39 and the vendors had said they could not accommodate the resident due to the resident being in a wheelchair. During an interview on 03/04/2025 at 2:38 PM, the Director of Nursing (DON) stated that social services should set up appointments with the dentist right away. The DON stated that for Resident #39, a dental appointment should have been scheduled. During a follow-up interview on 03/07/2025 at 10:25 AM, the DON stated that if there were any complaints about dental problems, staff should assess the pain and notify the doctor. She stated her expectation was that they obtain the dental consult as soon as possible. She said her expectation was to address the concern right away and then follow up as needed until the concern was resolved. The DON stated if the in-house vendor was not able to meet the resident's needs, social services was supposed to arrange a dental appointment with another dentist. The DON said social services should have arranged the appointment for Resident #39 earlier and should have found an outside dentist when the recommendation was made the first time. During an interview on 03/07/2025 at 11:04 AM, the Administrator stated his expectation was that staff make sure dental needs were provided either in-house or by outside sources if needed. He stated if dental needs were not able to be completed in-house, staff should get the appointment as soon as they were able. The Administrator stated for Resident #39, staff should have continued to follow up and reaching out to different sources to obtain the appropriate dental care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055475	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/07/2025
NAME OF PROVIDER OR SUPPLIER Main West Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 812 West Main Street Turlock, CA 95380	

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 35314 Based on observation and interview, the facility failed to ensure discarded items were secured inside of a dumpster. This deficient practice had the potential to affect all 96 residents who resided in the facility. Findings included: During an observation of the rear of the facility on 03/05/2025 at 10:19 AM, there was a cluttered area that contained 13 bags of clothing items, seven mattresses that were stained brown and stacked on top of a bed, a dusty plate warmer, and pallets. During an interview on 03/05/2025 at 10:25 AM, the Housekeeping Supervisor stated the items located at the rear of the facility had been there for three to six months and the maintenance staff were responsible for cleaning the area. During an interview on 03/05/2025 at 10:29 AM, Laundry Staff #5 stated the clutter of items had been located in the same area since she started working at the facility in 08/2024. During an interview on 03/05/2025 at 10:30 AM, the Maintenance Assistant (MA) stated some of the items were trash and other items were spart parts. Per the MA, every six to eight months, the facility rented a dumpster to throw away the items as the facility only had one dumpster and all the items would not fit in the dumpster. The MA stated the items that would be placed in the dumpster included wood pieces, mattresses that were stacked on top of a bed, wheelchair frames, chairs, headboards, a stack of 30 side rails, old shower chairs, fitted sheets for residents' beds, and an old bed. During an interview on 03/05/2025 at 11:00 AM, the Maintenance Director stated the cluttered area contained either items that needed to be repaired or items that needed to be discarded that could possibly attract pests. During an interview on 03/07/2025 at 7:32 AM, the Director of Nursing stated the area needed to be cleaned. During an interview on 03/07/2025 at 10:14 AM, the Administrator stated the area contained spare parts or items that needed to be disposed of. Per the Administrator, the area was not accessible to residents or their family but should be cleaned and without clutter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49044 Based on observation, interview, record review, and facility policy review, the facility failed to implement enhanced barrier precautions (EBP) for 2 (Resident #93 and Resident #252) of 21 sampled residents. Findings included: A facility policy titled Enhanced Barrier Precaution, dated 06/2022, revealed, Enhanced Barrier Precautions expand the use of PPE [personal protective equipment] and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs [multidrug-resistant organism] to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact activities. The policy specified, 1. Enhanced Barrier Precautions can be applied to residents with any of the following: a. Wounds or indwelling medical devices, regardless of MDRO colonization status such as but not limited to central line, urinary catheter, feeding tubes, tracheostomy/ventilator care). B. Infection or colonization with an MDRO. 2. Use EBP for high-contact resident care activities by using gown and glove during: a. Dressing b: Bathing/showering c. Transferring d. Provide hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care of use: central line, urinary catheter, feeding tube, tracheostomy/ventilator h. Wound care: any skin opening requiring a dressing. 1. An Admission Record revealed the facility admitted Resident #93 on 10/22/2024. According to the Admission Record, the resident had a medical history to include type 2 diabetes mellitus, direct infection of the left ankle and foot, and acquired absence of other left toes. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/26/2025, revealed Resident #93 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident had an infection of the foot, other open lesion(s) of the foot, and a surgical wound. Resident #93's Care Plan Report included a focus area initiated 01/09/2025, that indicated the resident had a surgical incision to the left transmetatarsal amputation site. Interventions directed staff to cleanse the surgical incision to the left transmetatarsal amputation site with normal saline, pat dry, apply a debriding agent/abdominal dressing and wrap with a sterile gauze every shift. During an observation on 03/05/2025 at 8:30 AM, the Treatment Nurse provided wound care to Resident #93's left foot and did not wear a gown. During an interview on 03/05/2025 at 9:25 AM, The Treatment Nurse acknowledged she did not wear a gown when she performed wound care for Resident #93. The Treatment Nurse stated she did not wear a gown because the resident's wound was not draining. Per the Treatment Nurse, she was aware of EBP and the only time she needed to implement EBP was when a resident had an open wound, a catheter, a tube feeding, or an intravenous line. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Main West Postacute Care	812 West Main Street Turlock, CA 95380

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/07/2025 at 9:02 AM, the Director of Nursing (DON) stated if a resident had an opened wound, staff should implement EBP when care was provided. The DON stated staff would be expected to wear a gown and gloves for any wound care treatments. During an interview on 03/07/2025 at 9:57 AM, the Administrator stated if a resident was on EBP, staff should wear a gown and follow precautions. 2. An Admission Record revealed the facility admitted Resident #252 on 02/28/2025. According to the Admission Record, the resident had a medical history to include a diagnosis of dysphagia (difficulty swallowing). An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/05/2025, revealed Resident #252 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had a feeding tube. Resident #252's Care Plan Report included a focus area initiated 03/02/2025, that indicated the resident was on enhanced barrier precautions related to a gastrostomy tube. During a concurrent observation and interview on 03/05/2025 at 4:30 PM, Licensed Vocational Nurse (LVN) #12 administered medications to Resident #252 by way the resident's gastrotomy tube. LVN #12 donned gloves but did not wear a gown. LVN #12 stated it was her mistake that she did not wear a gown. During an interview on 03/06/2025 at 3:14 PM, the Director of Staff Development (DSD) stated it had been explained to staff that if a resident had a gastrotomy tube, a catheter, or a wound, staff should wear a gown and gloves when they provide care to the resident. The DSD stated staff should wear the appropriate personal protective equipment, a gown and gloves, when they administer medications to a resident by of a resident's gastrostomy tube. During an interview on 03/07/2025 at 9:02 AM, the Director of Nursing stated it was expected of staff to wear a gown and gloves when they administer medications to a resident through the resident's gastrostomy tube. During an interview on 03/07/2025 at 9:57 AM, the Administrator stated if a resident was on EBP, staff should wear a gown and follow precautions.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on observation, interview, and document review, the facility failed to ensure residents' rooms measured at least 80 square (sq) feet (ft) per resident in 17 (Rooms 6 through 11 and Rooms 17 through 27) of 43 resident rooms in the facility. Findings included: During an observation on 03/03/2025 at 9:52 AM, three residents resided in room [ROOM NUMBER], Rooms 8 through 11, and Rooms 17 through 27. The Client Accommodations Analysis dated 03/06/2025, revealed the following: - In room [ROOM NUMBER], there was 78.7 sq ft for each resident. - In room [ROOM NUMBER], there was 77.4 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.8 sq ft for each resident. - In room [ROOM NUMBER], there was 76.2 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.5 sq ft for each resident. - In room [ROOM NUMBER], there was 78.4 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. - In room [ROOM NUMBER], there was 77.3 sq ft for each resident. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	- In room [ROOM NUMBER], there was 75.6 sq ft for each resident. During an interview on 03/07/2025 at 9:02 AM, the Director of Nursing stated she expected that the residents have as much room as needed in their room and for the facility to request the waiver for any rooms that did not meet the requirements. During an interview on 03/07/2025 at 9:30 AM, the Maintenance Director acknowledged the facility did have 17 resident rooms that were less than the required square footage, there was a waiver for those rooms, and three residents resided in each of the 17 rooms. During an interview on 03/07/2025 at 9:57 AM, the Administrator acknowledged the facility did have rooms that did not meet the required square footage.