

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Kingsburg Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Stroud Ave Kingsburg, CA 93631	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietitian. Based on interviews and record reviews, the facility failed to ensure the food service manager met state requirements when the Dietary Account Manager (DAM) hired for this role did not meet the qualifications required for food service managers. This failure had the potential to place residents at risk for compromised food safety and inadequate oversight of dietary operations for the 75 residents who received food from the kitchen. Findings: During a review of the California Health and Safety Code (HSC) 1265.4, dated 1/1/25, the California Health and Safety Code 1265.4 indicated seven qualification pathways of the full-time position responsible for the day-to-day operation of dietetic services. Pathway five indicated the manager is a graduate of a college degree program with major studies in food and nutrition, dietetics, food management, culinary arts, or hotel and restaurant management and is a certified dietary manager (CDM) credentialed by the Certifying Board of the Dietary Managers Association, maintains this certification, and has received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. During an interview on 6/2/26 at 8:15 a.m. with the DAM, the DAM stated she was employed full time and was the manager responsible for the day-to-day operations of the dietetic services at the facility. The DAM stated she had a bachelor's degree in hospitality recreation and tourism and was scheduled to take the CDM exam on 6/9/26. The DAM stated the Registered Dietitian Consultant (RDC) went to the facility every week for 8 hours and provided oversight and assistance while in the facility and stated she could reach out to the RDC as well via telephone with any questions or concerns she had at any time. During a review of the DAM's employee file (File), (undated), the file indicated a document titled, California State University, East Bay degree of Bachelor of Science in hospitality and tourism, dated May 13, 2023. The facility was unable to provide a certificate verifying that the DAM was a CDM. The DAM's file indicated her start date with the facility was on 12/10/25. During a concurrent interview and record review on 6/4/26 at 2:36 p.m. with the DAM and the Dietary District Manager (DDM), the California HSC 1265.4, dated 1/1/25 was reviewed. After reviewing the California HSC 1265.4, the DAM and the DDM stated they both believed the Bachelor of Science degree in hospitality and tourism held by the DAM met the requirements to qualify her as the manager of food and nutrition services. During a concurrent interview and record review on 6/4/26 at 3:10 p.m. with the Administrator (ADM) and the Regional Dietitian (RD), the California HSC 1265.4, dated 1/1/25 was reviewed. After reviewing the California HSC 1265.4, the ADM stated understanding of unmet requirements for the HSC 1265.4 regarding required qualifications for food service managers. During an interview on 6/5/26 at 1:45 p.m. with the RDC, the RDC stated she was present at the facility every week for 8-12 hours total and was not employed full time. The RDC stated it was her expectation to have a qualified food service manager and stated it was important to follow requirements and state mandates for a qualified person running the kitchen to ensure the facility was doing things according to regulations, meeting standards and for food safety and so staff have a qualified person to reach out to. During a review of the facility's policy and procedure (P&P) titled, Verification of Licensure, dated 04/07/2026, the P&P indicated, . This policy is (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055573	Facility ID: 055573 If continuation sheet Page 1 of 19

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to ensure that only legally qualified and/or otherwise appropriately qualified staff are employed according to state regulations and standards.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to establish and implement a comprehensive antibiotic (ATB) stewardship (program designed to reduce unnecessary use of antibiotics and to limit the spread of antibiotic resistance in bacteria) and surveillance program to identify, track, and monitor resident antibiotic use when the facility's ATB stewardship and surveillance program were incomplete for February 2026, March 2026, April 2026, and May 2026. These failures had the potential to place residents at risk for an adverse effect (bad reaction or unwanted result) of antibiotics and/or develop an antibiotic-resistant (not effective to treat infection) organisms from unnecessary or inappropriate antibiotic use. Findings: During a concurrent interview and record review on 6/5/26 at 8:58 a.m. with Infection Preventionist (IP), the facility's Surveillance Log (Log), dated February 2026, March 2026, April 2026, and May 2026 were reviewed. The IP stated she had been working for the facility for 10 years and assumed the position as IP in February 2026. The IP stated she tried her best to complete the antibiotic surveillance log (continuous, systematic monitoring of how bacteria develop defenses against medications [resistance] and how often doctors prescribed these drugs) as soon as she assumed the IP position. The IP stated the Log indicated for the months of February, March, April, and May, the surveillance log was incomplete. The IP stated the Log was missing signs (what the doctor or designee see) or symptoms (what you feel), no laboratory results, culture and sensitivity (C&S-two-part lab procedure used to identify the exact cause of an infection and find the best medication to cure it) or X-ray results (quick, painless test that uses invisible energy beams to take pictures of the inside of the body). The IP stated the Log should be complete and accurate to ensure residents were receiving the right antibiotic and were meeting the criteria for antibiotics. The IP stated she was not sure if the antibiotics ordered for residents were appropriate, not knowing whether the bacteria was susceptible (vulnerable) or resistant to the medication. The IP stated she was aware one of her main duties was to ensure residents were meeting the criteria to receive antibiotics and were beneficial to them. During an interview on 6/5/26 at 11:48 a.m. with the Director of Nursing (DON), the DON stated the IP took over the position in February 2026 after the previous IP left. The DON stated her expectation was for the IP to ensure the monthly antibiotic stewardship (infection surveillance log) was accurate and complete. The DON stated it was important for the IP to review the antibiotics used in the facility to ensure residents were prescribed the right antibiotic to prevent unnecessary medications which put residents at risk for developing tolerance to antibiotics. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, dated 9/18/23, the P&P indicated, . The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in or residents . When a culture and sensitivity (C&S) is ordered lab results and the current clinical situations will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified, or discontinued . During a review of the facility's P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, dated 9/18/23, the P&P indicated, . 2. The IP, or designee, will review antibiotics utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. 3. At the conclusion of the review, the provider will be notified of the review findings. 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking log . During a review of a professional reference from the CDC (Centers for Disease Control) found at www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html dated CDC (Centers for Disease Control), the Professional Reference titled, The Core Elements of Antibiotic Stewardship for Nursing Homes (found at www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html) indicated, . Leadership Commitment . Nursing home leaders commit to improving antibiotic use. Facility leadership, both owners and administrators, as well as regional and national leaders if the facility is part of a larger corporation, can demonstrate their support in the following ways . Communicate with (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing staff and prescribing clinicians the facility's expectations about use of antibiotics and the monitoring and enforcement of stewardship policies . Create a culture through messaging, education . which promotes antibiotic stewardship . Accountability . Nursing homes identify individuals accountable for the antibiotic stewardship activities who have the support of facility leadership . Empower the Director of Nursing to set the practice standards for assessing, monitoring and communicating changes in a resident's condition by front-line nursing staff. Nurses and nurse aides play a key role in the decision-making process for starting an antibiotic . Therefore, the importance of antibiotic stewardship is conveyed by expectations set by nursing leadership in the facility . Infection program coordinator . Infection program coordinators have key expertise and data to inform strategies to improve antibiotic use. This includes tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility . Tracking and Reporting Antibiotic Use and Outcomes . Process Measures: Tracking how and why antibiotics are prescribed . Perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians . Antibiotic use measures: tracking how often and how many antibiotics are prescribed . Track the amount of antibiotic used to review patterns of use and determine the impact of new stewardship interventions .		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to ensure the Notice of Medicare Non-Coverage (NOMNC) and Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) were completed and documentation was maintained demonstrating delivery of the notices to the resident and/or responsible party (RP) for one of three sampled residents (Resident 90). This failure had the potential to prevent Resident 90 and or RP from being fully informed of Medicare coverage termination, potential financial liability, and appeal rights. Findings: During an interview on 6/4/26 at 8:24 a.m. with the Minimum Data Set Nurse (MDSN), the MDSN stated the process for issuing a NOMC included discussing residents during weekly interdisciplinary team (IDT) meetings. The MDSN stated when a resident met their goals and was determined to be safe for discharge home, the IDT identified the last covered day. The MDSN stated she created the NOMC and provided the form to social services for completion. The MDSN further stated social services notified the residents and or RP and initiated discharge planning. During a concurrent interview and record review on 6/4/26 at 8:40 a.m. with the Social Services Assistant (SSA), Resident 90's electronic health record (EHR), dated 1/26/26 was reviewed. The SSA stated the Social Services Department was responsible for issuing beneficiary notification forms. The SSA stated the EHR indicated the facility provided the beneficiary notification documents for Resident 90 and stated the NOMNC was issued on 1/26/26. When asked what form was used to document the telephonic delivery of the NOMNC, the SSA was unable to provide an answer. The SSA stated she used the signed document when verbally delivering the SNF-ABN over the telephone but was unsure how the NOMNC was delivered. The SSA stated the NOMNC was likely delivered by telephone; however, she was unable to determine how the delivery was documented. The SSA stated she would generally document in a progress note how beneficiary notices were delivered; however, no progress note was identified in the EHR indicating how the NOMNC or SNF ABN were delivered. The SSA stated the NOMNC informed the resident and or RP of the date Medicare coverage would end and provided appeal rights if additional skilled services were believed to be necessary. When asked about the purpose of the SNF-ABN, the SSA stated it informed the resident and/or RP of Medicare non-coverage but was unsure what specific information the form provided. The SSA further stated the SNF ABN form had not been completed, as only the resident's name had been documented and no additional information had been entered on the form. When asked how she would proceed if a resident refused to sign the beneficiary notification forms, the SSA stated she could not answer and did not know the process. The SSA stated her usual practice was to read the forms aloud in person or over the telephone, answer questions, and ask how the resident or RP preferred to receive copies of the forms. The SSA stated if copies were mailed, she would complete an ICE CMS Optional Form 2/15 and document in a progress note that copies were provided and how they were delivered. The SSA stated the EHR indicated the ICE CMS Optional Form 2/15, which is the documentation indicating the beneficiary notification forms were mailed, or a progress note describing how the NOMNC or SNF ABN were delivered to the resident or RP could not be found. The SSA stated the previous Social Services Director (SSD) did not complete the portion of the telephonic delivery form indicating the forms were mailed and did not complete an ICE CMS Optional Form 2/15. The SSA stated she believed the previous SSD may have used the telephonic delivery form for both the NOMNC and SNF ABN. The SSA stated beneficiary notification forms were important because they were part of the resident's rights. During an interview on 6/5/26 at 1:30 p.m. with the Administrator (ADMIN), the ADMIN stated his expectation regarding issuance of the NOMNC and SNF ABN forms was that the IDT met and determined when Medicare coverage would end for residents receiving Medicare services. The ADMIN stated the MDSN prepared the NOMNC and the Social Services Department issued the beneficiary notification forms. The ADMIN stated the Social Services Department provided the notices to the residents and/or RP, and Medical Records uploaded copies of the completed forms into the residents EHR. The ADMIN stated the residents, or RP signed the notices in person when (continued on next page)		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	available and if the resident or RP was unavailable to sign, the facility attempted to fax or mail notices. The ADMIN stated a progress note should have been completed documenting how the notices were delivered. The ADMIN stated his expectation was that the NOMNC should have been completed and signed, the SNF ABN should have been completed, and any mailing of beneficiary notification forms should have been documented. The ADMIN stated this process was important because residents had rights to be informed of information affecting their Medicare coverage and appeal rights. During a review of facility policy and procedure (P&P) titled, Medicare and Medicaid Benefits, revised date 4/2021, the P&P indicated, .when changes are made to items and services covered by Medicare or Medicaid plans, residents are informed of these changes as soon as possible.During a review of facility P&P titled, Medicare Advanced Beneficiary and Medicare Non-Coverage Notices, undated, the P&P indicated, .written notices are provided in person to the beneficiary when possible. A copy of the notice is provided to the beneficiary (or authorized representative) immediately after the notice is signed.During a review of facility P&P titled, Acknowledgement of Resident Rights and Responsibilities, undated, the P&P indicated, .each resident (or resident representative) will be provided and must acknowledge receipt of a written copy of resident rights and all rules, regulations and policies governing the resident's conduct and responsibilities during his/her stay in the facility.signed dated copies of the residents acknowledgement of rights and responsibilities and any subsequent revisions are maintained in the residents medical record.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide the required bed-hold notice at the time of transfer to the hospital for two of six sampled residents (Resident 1 and Resident 13), when: 1. Resident 1 was transferred to the hospital on 3/8/26 due to low oxygen levels and was not given the required facility document titled, Bed Hold Notice of Policy & Authorization (BHNPA). 2. Resident 13 was transferred to the hospital on 5/25/26 due to shortness of breath (SOB-the feeling that you cannot get enough air into your lungs) and was not given the required facility document BHNPA. These failures had the potential to result in Resident 1 and Resident 13 being unaware of their right to return to the facility under state and federal laws and regulations and the option to privately pay to hold their bed if they were a Medicare beneficiary, private pay resident, or insurance resident. Findings: 1. During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 6/5/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses of Covid-19 (a highly contagious respiratory illness caused by the SARS-CoV-2 virus) acute and chronic respiratory failure with hypercapnia (when the lungs cannot properly remove carbon dioxide [a colorless, odorless gas at room temperature] from your blood leading to a dangerous buildup), pneumonia (inflammation and fluid in the lungs caused by a bacterial, viral, or fungal infection) unspecified organism, heart failure unspecified, muscle weakness (generalized), other abnormalities of breathing, mixed irritable bowel syndrome (alternating bouts of constipation and diarrhea). The AR indicated under the contacts section of the document that Resident 1 was her own responsible party (RP-indicates that the resident holds the legal, medical, and financial authority over their own care). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/24/26, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 1 was cognitively intact. During a review of Resident 1's facility document titled, BHNPA, dated 3/8/26, the BHNPA indicated, .Resident Name.[Resident 1's name listed].Agreement to Pay Charges Privately for Bed Hold.Resident/Representative [area for signature blank].Date [blank].During a concurrent interview and record review on 6/5/26 at 8:44 a.m. with the Medical Records (MR), the policy and procedure (P&P) titled, Bed-Holds and Returns, dated October 2022 and Resident 1's EHR, undated were reviewed. The MR stated she could not state whether the Bed Hold Notice of Policy & Authorization form was provided to Resident 1 when being transferred to the hospital, upon her return from the hospital (a couple of hours later the same day) or within the required 24hr period timeframe as stated in the P&P. The MR stated the EHR indicated based on the inability to provide the signed document by the resident, and no documentation in Resident 1's chart whether the form was provided to the resident, the P&P was not followed. The MR stated it was important to complete and provide residents' with written notices for all transfer documents including the BHNPA form to honor resident's rights and for the resident to be informed. 2. During a review of Resident 13's AR, dated 6/5/26, the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of interstitial pulmonary disease unspecified (inflammation, scarring, or both in the tiny tissues that surround the air sacs in your lungs), pulmonary candidiasis (fungal infection of the lungs), pulmonary fibrosis (chronic lung disease characterized by buildup of scar tissue in the lungs), acute respiratory failure with hypoxia (a sudden, life threatening condition where the lungs cannot get enough oxygen (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	into the bloodstream), heart failure (when the heart is too weak or stiff to pump blood efficiently), major depressive disorder (a serious mental health condition that causes a deep, persistent feeling of sadness or a loss of interest in activities). The AR indicated under the contacts section of the document that Resident 13 was his own RP. During a review of Resident 13's MDS, dated [DATE], the MDS section C indicated Resident 13 had a Staff Assessment for Mental Status. Section C0700. Short-term Memory OK indicated, 0. Memory OK and section C1000. Cognitive Skills for Daily Decision Making indicated, 1. Modified Independence-some difficulty in new situations only. During a concurrent interview and record review on 6/4/26 at 10:33 a.m. with the MR, Resident 13's EHR, date 5/25/26 was reviewed. The MR stated nurses were to complete a three page packet for every discharge or transfer that included: First page -Ombudsman Transfer or Discharge Fax Cover Sheet, 2nd page- Notice of Proposed Transfer and Discharge (to be signed by resident) and 3rd page- Bed Hold Notice of Policy & Authorization (BHNPA) (to be signed by resident). The MR stated the EHR indicated she did not have the BHNPA form and the form was not in the EHR for Resident 13's most recent transfer. The MR stated she had been having issues with the nurses because not all nurses were completing the required three-page document packets upon transfers and stated it was possible the BHNPA form did not get filled out for Resident 13's transfer on 5/25/26. The MR stated not all nurses completed the forms as required. The MR stated she had noticed quite a bit of items that were not consistent with documents and paperwork and needed to figure out a plan to correct this issue, so the three-page document packets were filled out and there was consistency every time. The MR stated it was important to have completed paperwork for every transfer or discharge so the Ombudsman could keep track of the discharge (DC) to ensure it was safe and necessary and so that residents could be informed of the information and their rights regarding the bed hold. During an interview on 6/5/26 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated during a transfer nurses knew there was a three-page document packet which included the Transfer or Discharge Fax cover sheet, Notice of Proposed Transfer and Discharge form and the Bed Hold Notice of Policy & Authorization form which needed to be filled out and was a requirement for every transfer. LVN 1 stated it was important for the nurses to ensure the Transfer or Discharge Fax cover sheet, Notice of Proposed Transfer and Discharge form and the Bed Hold Notice of Policy & Authorization form was provided to the residents, so residents knew and were aware of their rights to return to the facility and residents knew that they had that option. LVN 1 stated providing residents with the BHNPA form was important because returning to the facility was usually a big concern to the residents when being transferred out. During an interview on 6/5/26 at 1:16 p.m. with the Director of Nursing (DON), the DON stated it was important for all transfer paperwork including the BHNPA form to be completed when a resident was transferred to the hospital to inform the doctor and family and so that residents could be informed of their rights for bed hold during transfers. During a review of the facility's P&P titled, Bed-Holds and Returns, dated 10/2022, the P&P indicated, .Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. Residents, regardless of payer source, are provided written notice about these policies. at the time of transfer (or, if the transfer was an emergency, within 24 hours).		

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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 the Minimum Data Set Assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for two of six sampled residents (Resident 2 and Resident 84) when: 1. Resident 2's surgical incision was not coded in the quarterly MDS assessment dated [DATE]. 2. Resident 84's use of oxygen was not coded in the annual MDS assessment dated [DATE]. These failures had the potential for Resident 1 and Resident 84's needs to not be met and changes in status not monitored which could lead to wound and respiratory complications. Findings: 1. During an observation on 6/3/26 at 11:40 a.m. with Resident 2, Resident 2 was sitting up in her wheelchair in the dining/activity room with other residents. Resident appeared well groomed holding on to a doll while another resident was trying to engage her to talk. Resident 2 did not respond to questions asked but was mumbling with words. During a review of Resident 2's admission Record (AR- a document containing resident profile information), dated 6/4/26, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included atrial fibrillation (irregular heartbeat), end stage renal disease (ESRD- irreversible kidney failure) and diabetes mellitus (DM-disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's Order Summary Report (OSR), dated 6/4/26, the OSR indicated, . [status post (S/P)] right [R] thoracotomy [surgical procedure to open the chest] incisions [cut] to [R] lateral ribs cleanse with [normal saline (NS)- salt water], pat dry . Order Date: 2/9/26 . Start Date: 2/10/26. During an interview on 6/4/26 at 9:25 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 2's care. CNA 1 stated Resident 2 had a dressing on her back. CNA 1 stated she was not sure what Resident 2 had under the dressing because she had never watched the nurse change the dressing. CNA 1 stated she only knew the nurse changed the dressing every day. During an interview on 6/4/26 at 9:55 a.m. with CNA 2, CNA 2 stated she was familiar with Resident 2's care. CNA 2 stated Resident 2 did not have any pressure ulcers, but she had seen the nurse change the dressing on Resident 2's back. CNA 2 stated Resident 2 had surgery done on her back but was not sure how long. During a concurrent interview and record review on 6/4/26 at 2:10 p.m. with the Director of Staff Development (DSD), Resident 2's electronic health record (EHR), undated was reviewed. The DSD stated the EHR indicated Resident 2 had a thoracentesis (chest tap-procedure where a doctor uses a small needle and tube to drain excess fluid from space just outside the lungs) performed at the acute hospital. The DSD stated she was not sure of the date it was performed. The DSD stated the treatment order was still active. During a concurrent interview and record review on 6/4/26 at 3:29 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 2's EHR, undated was reviewed. LVN 2 stated the EHR indicated Resident 2 had a surgical wound on her right side. LVN 2 stated the dressing change on her right side was changed daily during the morning shift. LVN 2 stated she was not sure if the wound had healed because the treatment was still active and was signed every day indicating the treatment was completed daily. During an interview on 6/4/26 at 4:38 p.m. with the Minimum Data Set Nurse (MDSN), Resident 2's quarterly MDS assessment section M (Skin Conditions), dated 5/5/26 was reviewed. The MDSN stated Resident 2's surgical wound and surgical wound care was not coded in the quarterly MDS assessment. The MDSN stated Resident 2 should have been coded as having a surgical wound and receiving care for her surgical wound. The MDSN stated Resident 2's quarterly MDS assessment did not accurately reflect Resident 2's status. 2. During an observation on 6/2/26 at 9:32 a.m. during initial tour in Resident 84's room, Resident 84 was lying in bed, oxygen via nasal cannula (nasal prongs- thin, flexible plastic tube) connected to oxygen concentrator (medical device that gives you extra oxygen) and set at three liters (L-unit of measurement) per minute. Resident 84 did not respond to questions asked. During a review of Resident 84's AR, dated 6/4/26, the AR indicated Resident 84 was admitted to the facility on [DATE] (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with diagnoses which included unspecified intracranial injury (head injury-any physical damage to the brain or skull), hydrocephalus (water on the brain) and palliative care (specialized medical care for anyone living with a serious illness). During a review of Resident 84's OSR, dated 6/4/26, the OSR indicated, . Oxygen two - four [2-4] L/min [liter per minute] via nasal cannula, [oxygen (O2)] saturation to remain above 90 percent [%] as needed for shortness of breath [SOB] . order date: 3/10/26, start date: 3/10/26. During an interview on 6/4/26 at 9:19 a.m. with CNA 1, CNA 1 stated she was familiar with Resident 84's care. CNA 1 stated Resident 84 was dependent on staff to meet all his daily needs like turning and repositioning, bathing, and dressing. CNA 1 stated Resident 84 had always used oxygen since she could remember. CNA 1 stated she did not remember Resident 84 not using oxygen.During an interview on 6/4/26 at 3:40 p.m. with LVN 2, LVN 2 stated she worked afternoon shift and was familiar with Resident 84's care. LVN 2 stated Resident 84 had always been on continuous oxygen as long as she could remember. During a concurrent interview and record review on 6/4/26 at 4:29 p.m. with the MDSN, Resident 84's annual MDS assessment section J (Health Conditions), dated 5/26/26 was reviewed. The MDSN stated the MDS indicated she answered No, Resident 84 did not receive oxygen. The MDSN stated she based her answer on the review of documentation from nursing staff and did not interview staff. The MDSN stated Resident 84's use of oxygen was not coded accurately in the annual MDS assessment. The MDSN stated Resident 84 should have been coded as receiving oxygen. The MDSN stated it was her responsibility to ensure resident assessments were accurate. The MDSN stated it was important to ensure accurate assessments were completed because it reflected the care provided to each resident.During an interview on 6/5/26 at 11:45 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the MDSN to do bedside assessments of residents to ensure accuracy of assessments and not rely on documentation from staff. The DON stated each member of the nursing staff completing a section in the MDS was responsible for ensuring their assessments were accurate to provide the care needed by residents.		

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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. **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 two of five sampled residents (Residents 27 and 84), when: 1. Resident 27's physician order for daily dressing changes to the left breast wound were not followed. This failure had the potential to increase the risk of infection and result in inaccurate medical record documentation. 2. Resident 84's physician order for oxygen was not followed, and there was no documentation and monitoring of oxygen saturation (measures the percentage of oxygen in the blood). This failure placed Resident 84 at risk for receiving too much oxygen or too little oxygen without adequate monitoring which could cause damage to the lungs, brain, and eyes. Findings: 1. During a concurrent interview and observation on 6/2/26 at 9:01 a.m. in Resident 27's room, Resident 27 stated staff had not changed the dressing to her left breast as ordered. Resident 27 stated the dressing was to be changed daily and had not been changed for two days. Resident 27 then displayed the dressing to the surveyor. Observation revealed the dressing was dated 5/30/26. During a review of Resident 27'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 6/5/26, the AR indicated Resident 27 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm (cancer, a disease in which abnormal cells grew uncontrollably and can spread to other parts of the body) of unspecified site of left female breast (the exact location of the cancer within the left breast was not identified in the medical record). During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/10/26, the MDS indicated Resident 27 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 27 was cognitively intact. During a concurrent interview and record review on 6/5/26 at 9:37a.m. with Licensed Vocational Nurse (LVN) 1, Resident 27's electronic health record (EHR), dated 6/5/26 was reviewed. LVN 1 stated Resident 27 had two wound care orders, including an order for the left breast area to be cleansed with normal saline (a sterile solution used to clean wounds and help prevent infection) and covered with a dry dressing once daily. LVN 1 stated the EHR indicated the left breast dressing change was documented on the TAR as completed daily from 5/30/26 through 6/3/26. LVN 1 stated the process for completing and documenting wound treatments was to perform the treatment and then document completion on the TAR. LVN 1 stated dressings were expected to be dated and initialed when changed and that dating and initialing dressings was important to verify treatments were completed as ordered, confirmed the frequency of dressing changes and support infection prevention practices. LVN 1 stated resident refusals were documented on the TAR. LVN 1 stated the EHR indicated there was no documentation indicating Resident 27 had refused dressing changes on 5/31/26, 6/1/26 or 6/2/26. When informed that observation on 6/2/26 revealed a dressing dated 5/30/26 remained in place on Resident 27's left breast, LVN 1 stated a dressing dated 5/30/26 on (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/2/26 would not have been consistent with daily dressing changes and indicated the treatments had been missed. LVN 1 further stated it would not have been accurate to document a dressing change as completed if the treatment had not been performed. When asked how a dressing dated 5/30/26 remained in place on 6/2/26 when the TAR indicated daily dressing changes had been completed, LVN 1 stated, It was obviously not done. LVN 1 stated the risk of not completing the dressing change as ordered was potential for infection due to the wound not being cleansed and redressed as prescribed. During a review of Resident 27's Care Plan Report (CP), dated 4/3/26, the CP indicated Resident 27 was identified as being at risk for unavoidable skin breakdown and had an open wound to the left breast. The CP indicated interventions included providing wound treatment as ordered. During an interview on 6/5/26 at 9:55 a.m. with the Director of Nursing (DON), the DON stated it was her expectation that staff followed physician orders for dressing changes. The DON stated nursing staff should assess the wound area, complete the dressing change and notify the physician of any changes in the wound condition. The DON stated wound treatments were verified as completed through documentation on the TAR. The DON stated if a dressing dated 5/30/26 remained in place on 6/2/26, that would indicate the dressing had not been changed. The DON further stated a dressing dated 5/30/36 on 6/2/26 would not be consistent with an order for daily dressing changes. The DON stated it would not be accurate documentation if a treatment was marked as completed when it had not been performed. The DON stated the risk to the resident from not completing ordered dressing changes was infection and stated, This is not my expectation. During a review of the facilities policy and procedure (P&P) titled, Charting and Documentation, undated, the P&P indicated, documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care. 2. During an observation on 6/2/26 at 9:32 a.m. during initial tour in Resident 84's room, Resident 84 was lying in bed, oxygen via nasal cannula (nasal prongs- thin, flexible plastic tube) connected to oxygen concentrator (medical device that gives you extra oxygen) and set at three liters (L-unit of measurement) per minute. Resident 84 did not respond to questions asked. During a review of Resident 84's admission Record (AR-a document containing resident profile information), dated 6/4/26, the AR indicated Resident 84 was admitted to the facility on [DATE] with diagnoses which included unspecified intracranial injury (head injury-any physical damage to the brain or skull), hydrocephalus (water on the brain) and palliative care (specialized medical care for anyone living with a serious illness). During a review of Resident 84's Order Summary Report (OSR), dated 6/4/26, the OSR indicated, . Oxygen two &ndash; four [2-4] L/min [liter per minute] via nasal cannula, [oxygen (O2)] saturation to remain above 90 percent [%] as needed for shortness of breath [SOB] . order date: 3/10/26, start date: 3/10/26. During an interview on 6/4/26 at 9:19 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 84's care. CNA 1 stated Resident 84 was dependent on staff to meet all his daily needs like turning and repositioning, bathing, and dressing. CNA 1 stated Resident 84 had always used oxygen since she could remember. CNA 1 stated she did not remember Resident 84 not (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	using oxygen. During an interview on 6/4/26 at 9:50 a.m. with CNA 2, CNA 2 stated she was familiar with Resident 84's care. CNA 2 stated Resident 84 did not respond when spoken to. CNA 2 stated Resident 84's oxygen was always on since she started working with him when he was moved to room [ROOM NUMBER] but do not remember how long. During a concurrent interview and record review on 6/4/26 at 2:10 p.m. with the Director of Staff Development (DSD), Resident 84's oxygen order, dated 3/10/26 and Resident 84's electronic medical record (EMR), dated 6/1/26-6/30/26 were reviewed. The DSD stated the oxygen order indicated oxygen was ordered as needed, and was to be given only to maintain his oxygen saturation above 90%. The DSD stated Resident 84's oxygen was always on, but she did not find documentation in the EMR to indicate the oxygen saturation was checked. The DSD stated there should have been documentation or monitoring of Resident 84's oxygen saturation but there was none. The DSD stated a resident given oxygen when not needed could lead to confusion, disorientation, and unresponsiveness. During a concurrent interview and record review on 6/4/26 at 3:40 p.m. with LVN 2, Resident 84's EMR, dated 6/1/26-6/30/26 was reviewed. LVN 2 stated she was familiar with Resident 84's care. LVN 2 stated Resident 84's oxygen order was not followed. LVN 2 stated the EHR indicated Resident 84's oxygen order was as needed to keep oxygen saturation above 90%. LVN 2 stated Resident 84 had always been on continuous oxygen as long as she could remember. LVN 2 stated she did not remember checking and monitoring oxygen saturations and did not remember documenting in the electronic Medication Administration Record (eMAR-digital checklist used by nurses and caregivers) or the electronic Treatment Administration Record (eTAR-digital checklist) for Resident 84. LVN 2 stated she could not find Resident 84's documentation of oxygen saturation results in the EMR. LVN 2 stated it was important to monitor and document Resident 84's oxygen saturation but there was none. During an interview on 6/5/26 at 11:20 a.m. with the DON, the DON stated the oxygen order needed to be followed. The DON stated her expectation was for the licensed nurses to monitor and document the oxygen saturation of Resident 84 and notify the medical doctor to change the order if Resident 84 had been using oxygen continuously. The DON stated there should have been documentation and monitoring of Resident 84's oxygen saturation to justify why he was on oxygen but there was none. During a review of facility's P&P titled, Oxygen Therapy, dated 4/7/26, the P&P indicated, .Verify physician order.Oxygen therapy must be initiated based on a physician's order or facility-approved standing order. The order should be updated as settings/lpm [liter per minute] change. Monitoring: 1) Continuous or intermittent pulse oximetry per condition and physician order. 2) Reassess and document peripheral capillary oxygen saturation [SpO2-blood oxygen level or oxygen saturation]: a. At least every shift. b. After titration. c. With changes in condition. d. Document resident tolerance, respiratory status, and interventions. Notify physician if: . SpO2 is persistently below or above the target range despite titration [process of finding the exact right dose of supplemental oxygen]. Obtain new orders as needed.Documentation 1. Record: a. Date/time of titration. B. Flow rate before and after adjustment. c. SpO2 levels and resident response. d. Reason for change.		

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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 daily nurse staffing information was consistently posted in a prominent location that was readily visible and accessible to residents, and visitors, in accordance with regulatory requirements. The facility census was eighty residents. This failure had the potential to prevent residents, visitors and family members from readily accessing required staffing information necessary to make informed decisions regarding resident care and services. Findings: During a concurrent observation and interview on 6/3/26 at 12:28p.m. with the Administrator (ADMIN), the surveyor observed the main lobby and other prominent locations within the facility in an attempt to locate the posted daily nurse staffing information. The ADMIN approached surveyor and asked if assistance was needed. When the ADMIN was informed the surveyor was looking for the posted nurse staffing hours, the ADMIN stated the staffing hours were not posted. The ADMIN then reached over the nurses' station counter, retrieved an unlabeled binder, and presented a daily work schedule, stating this is what they used. During an interview on 6/4/26 at 3:36 p.m. with the Director of Staff Development (DSD) and the Infection Preventionist (IP), the DSD stated it was her responsibility to ensure there were no gaps in the staffing schedule. The IP stated the facility posted the Form CMS-612 using information from the previous day. The IP stated the facility utilized the census report and daily assignment sheets from both the previous and current day to complete the posting and that this task was completed daily. The IP stated the actual hours worked were to be posted. When asked whether the required staffing information had been posted on 6/3/26, the IP stated the staffing information was posted following the surveyor's interview with the ADMIN regarding the absence of the staffing posting. The IP further stated it was not a consistent practice to post the staffing information. When asked whether a resident or visitor would have been able to locate the required staffing information on 6/3/26, the IP stated the information would have needed to be requested from the scheduler. The IP stated it was important for staffing information to be readily available to residents and visitors because it promoted communication, provided reassurance regarding resident care and helped ensure residents and family members felt comfortable and safe. During a concurrent interview and record review on 6/4/26 at 3:59 p.m. with the DSD and the IP, the Appendix PP tag F732, dated 2/3/23 was reviewed. The DSD and the IP escorted the surveyor to the location where the daily nurse staffing information had been posted following identification of the concern. The posting was located on a wall in the facility's main lobby. The DSD and the IP stated the Appendix PP tag F732 indicated, the daily nurse staffing information was required to be posted each day in a prominent location that was readily visible and accessible to residents and visitors and that the posting was required to occur consistently. The DSD and the IP stated after reviewing the Appendix PP, they now understood the requirements of the facility to post the nurse staffing information. During a concurrent interview and record review on 6/5/26 at 10 a.m. with the Director of Nursing (DON), the Appendix PP tag F732, dated 2/3/23 was reviewed. The DON stated her expectation was to maintain sufficient staffing to provide care to residents. The DON stated it was important for residents and visitors to know there was adequate staff available to provide care. The DON further stated posting the staffing information in a visible location had not previously been a consistent practice. The DON stated the Appendix PP indicated daily nurse staffing information was required to be posted each day in a prominent location that was readily visible and accessible to residents and visitors and that the posting was required to occur consistently. The DON stated after reviewing the Appendix PP, she verbalized understanding that daily nurse staffing information was required to be posted daily in a prominent location. During a review of facilities policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, undated, the P&P indicated, within two hours of the beginning of each shift, the number of licensed nurses and number of unlicensed nursing personnel directly responsible for resident care is posted in a prominent location (accessible to residents and visitors) and in a clear and readable format.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (medicines or products made from living organisms) was labeled in accordance with current professional standards of practice and facility procedures for one of four sampled residents (Resident 84), when Resident 84's morphine sulfate (strong opioid pain medication) medication label directions did not match the medication order in the electronic medical administration record (EMAR-digital version of a patient's medication chart). This failure placed Resident 84 at risk of receiving too much or too little pain medication which could lead to more serious health conditions such as not experiencing pain relief or slow or shallow breathing or even unconsciousness. Findings: During a review of Resident 84's admission Record (AR-a document containing resident profile information), dated 6/4/26, the AR indicated Resident 84 was admitted to the facility on [DATE] with diagnoses which included unspecified intracranial injury (head injury-any physical damage to the brain or skull), hydrocephalus (water on the brain) and palliative care (specialized medical care for anyone living with a serious illness). During a review of Resident 84's Order Summary Report (OSR), dated 6/4/26, the OSR indicated, . Morphine Sulfate (Concentrate-) Oral Solution 100 [milligram (MG)-unit of measurement]/five [5] [milliliter (ML)-unit of measurement] (Morphine Sulfate) Give 0.5 ml via [through] G-tube [gastrostomy tube-soft, flexible feeding tube placed directly into the stomach through a small opening in the abdomen] every 4 [four] hours for pain. Order Date: 5/23/26, Start Date: 5/23/26. During medication administration observation on 6/4/26 at 11:21 a.m. in station four with the Director of Staff Development (DSD), the DSD prepared Resident 84's medications including Morphine Sulfate. The DSD entered Resident 84's room and administered medications through the G-tube. During a concurrent interview and record review on 6/4/26 at 1:43 p.m. with the DSD, Resident 84's electronic health record (EHR), dated 6/1/26-6/31/26 and Resident 84's morphine sulfate medication label (Label), dated 5/22/26 were reviewed. The DSD stated, There are so many things that went wrong during the medication pass. The DSD stated during medication pass, the practice was to check and compare the medication order directions and the directions on the medication label to make sure they were the same. The DSD stated the EHR indicated Resident 84's morphine sulfate order was to be administered through the G-tube. The DSD stated the label indicated the morphine sulfate directions on the medication box was to give medication by mouth or under the tongue. The DSD stated she should have clarified the order with Resident 84's doctor because the direction on the medication label and the order were not the same. The DSD stated she did not call Resident 84's doctor and she should have. During a concurrent observation and interview on 6/4/26 at 3:45 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated she worked full time on the afternoon shift and was familiar with Resident 84's care. LVN 2 stated during medication pass the practice was to compare the medication label directions with the medication order to prevent a medication error. LVN 2 stated she administered Resident 84's morphine sulfate through his G-tube. LVN 2 checked Resident 84's morphine sulfate medication label directions and stated, The direction in the label was to give the medication by mouth or under the tongue. LVN 2 stated she was not aware and just assumed all medications were given through the G-tube since Resident 84 was nothing by mouth (NPO). LVN 2 stated when a medication label direction and medication order were not the same, the medical doctor (MD) should have been called to clarify the order. During an interview on 6/5/26 at 10:15 a.m. with LVN 1, LVN 1 stated, You have to compare the medication direction with the order and make sure they matched. LVN 1 stated the MD should be called to clarify orders if the medication directions and the order did not match. LVN 1 stated the pharmacy should also be notified to correct the label direction to match the order. LVN 1 stated the nurse could also place a Direction Changed (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sticker until pharmacy sent a new medication.During an interview on 6/5/26 at 11:07 a.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to always compare the medication label with the eMAR. The DON stated, If instructions or directions does not match, call pharmacy and have them send new medication with new instruction. The DON stated not comparing medications could lead to medication errors which could lead to health complications. During a review of the facility policy and procedure (P&P) titled, Medication Labels, dated 4/14, the P&P indicated, .Labels are permanently affixed to the outside of the prescription container. Each prescription medication label includes: 1) Resident's name 2) Specific directions for use, including route of administration. If the physician's directions for use change or the label is inaccurate, the nurse may place a change of order label on the container indicating there is a change in directions for use. When such a label appears on the container, the medication nurse checks the resident's medication administration record (MAR) or the physician's order for current information.		

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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 to store, prepare, distribute and serve food in accordance with professional standards for food service safety when: 1. One of three dietary staff (Dietary Aid [DA]) did not have facial hair (mustache) properly restrained. 2. A [Brand name] (a commercial-grade food processor machine) lid had left over residue of food and was stored on a standing rack that contained dry, clean, and ready-to-use equipment. These failures had the potential to cause cross contamination (the process by which germs are unintentionally transferred from one substance or object to another, with harmful effect) and the growth of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) of residents' food which could lead to food-borne illness (stomach illness acquired from ingesting contaminated food) for the 75 residents admitted to the facility who received meals from the kitchen. Findings: 1. During a concurrent observation and interview on 6/2/26 at 8:30 a.m. with the Dietary Account Manager (DAM) in the kitchen, the DA was observed working in the kitchen with an exposed mustache and facial hair not restrained. The DAM stated the DA had exposed hair and the expectation was that all employees washed their hands and donned (to put on) hair nets, including facial hair coverings, so all hair was covered while in the kitchen. The DAM stated it was important for all hair to be covered in the kitchen so there was no physical contamination (any foreign objects that accidentally get into the food) of the food. The DAM stated hair could also get on the plates and that would cause contamination that could lead to foodborne illness. During an interview on 6/5/26 at 1:42 p.m. with the Registered Dietitian Consultant (RDC), the RDC stated her expectation was that staff in the kitchen wore hair restraints and facial hair coverings including beard and mustache coverings anywhere and anytime they were in the kitchen. The RDC stated it was important that hair restraints and facial coverings were worn because it was not sanitary for hair to be exposed and there was a risk for cross- contamination of food that could lead to foodborne illness. During a review of the facility's policy and procedure (P&P) titled, Staff Attire, dated 10/2023, the P&P indicated, .All staff members will have their hair off the shoulders, confined in a hair net or cap, and facial hair properly restrained. 2. During a concurrent observation and interview on 6/2/26 at 9:30 a.m. with the DAM in the kitchen, a [Brand name] lid was observed with leftover food residue stored on a standing rack. The DAM stated all bowls, pans, equipment etc., including the [Brand name] that was on the standing rack was dry, clean and ready for use. The DAM stated there was left over residue of food on the [Brand name] lid. The DAM stated it was her expectation to not have leftover food on equipment after an item has been washed and cleaned. The DAM stated the left-over food could have mold and stated left over food residue could contaminate other foods going into that equipment if not properly cleaned and sanitized. The DAM stated improperly cleaned and sanitized equipment could lead to cross-contamination and foodborne illness. During a review of the facility's P&P titled, Equipment, dated 9/2017, the P&P indicated, .All foodservice equipment will be clean, sanitary, and in proper working order. During a review of the facility's P&P titled, Food: Preparation, dated 2/2023, the P&P indicated, .Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological [living microorganisms such as bacteria, viruses, and parasites], and chemical contamination [when food is accidentally tainted by toxic substances used in the kitchen environment].		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055573	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2026
NAME OF PROVIDER OR SUPPLIER Kingsburg Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Stroud Ave Kingsburg, CA 93631	
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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure essential equipment was maintained in safe operating condition when pipes on top of two of two washers in the laundry room were observed covered with thick white and green build up. This failure had the potential to affect the efficiency of the washers to clean the personal clothing of 80 residents and linens used in the facility. Findings: During a concurrent observation and interview on 6/4/26 at 8:30 a.m. in the laundry room with Laundry Person (LP) 1, observed two washers with thick white and green hard build up around the pipes connected to the top of the washers. LP 1 stated she did not remember cleaning the top of the washers and was not sure who was responsible to clean the top of the washers. LP 1 stated she only cleaned the lint trap on the bottom of the dryers and wiped down the front lid of the washers. During a concurrent observation and interview on 6/4/26 at 8:33 a.m. in the laundry room with the Housekeeping/Laundry Account Manager (HLAM), the HLAM stated there was thick white and green hard build up covering the pipes on top of each washer. The HLAM stated he was not sure who was responsible to clean and maintain the top of the washers. The HLAM stated laundry staff only wiped down the front of the washers and not the top. The HLAM stated he was not sure if it was part of their contract to clean the top of the washers. The HLAM stated the heavy build up around the pipe could eventually affect the machines efficiency and would affect routine washing of linens and residents personal items. The HLAM stated he will start to include daily cleaning of the top of the washers to not disrupt the routine cleaning schedule. During a concurrent observation and interview on 6/4/26 at 8:35 a.m. with the Director of Maintenance (DM) in the laundry room, the DM stated the white build up on top of the washers were calcium deposits (crusty, chalky white residue left behind when hard water evaporates or is heated up by the machine). The DM stated it would potentially affect the machine making it work harder and could cause the washer to break down prematurely. The DM stated he was not sure who was responsible to maintain and clean the machines. The DM stated he would include the cleaning of the machine to his to do list and would inspect the washers at least weekly. During an interview on 6/5/26 at 1:12 p.m. with the Administrator (ADM), the ADM stated he talked to the manager of the contract company providing housekeeping, laundry, and dietary services to the facility. The ADM stated there was no clear writing in their contract whose responsibility it was to maintain the equipment, but It does not mean it is not their responsibility. The ADM stated he saw the buildup on top of the machines and did not think it affected how the machine washed clothes and linens. The ADM stated the machines still needed to be maintained and the DM will be inspecting washers regularly and laundry staff will be cleaning machines after each use or before their shift ends. During a review of facility document titled, Washer-Extractors, maintenance manual guide, dated 7/18, the maintenance manual guide indicated, . Routine maintenance maximizes operating efficiency and minimizes downtime . Beginning of Day . Inspect the water inlet valve hose connections . Inspect the chemical connections for machines equipped with an automatic chemical system by inspecting all connections and chemical hoses for leaks or cracks . End of Day . Clean the machine's exposed surfaces with all-purpose cleaner . During a review of facility document titled, Director of Maintenance, Job Description, revised date 7/24, the document indicated, . Conduct ongoing inspections of facility to identify areas and equipment requiring improvement/repairs. Develop and implement a preventative maintenance program including routine inspection and servicing. Examine equipments, systems and physical plants [i.e., buildings] to determine needed installations, service or repairs. Supervise work of contractors in connection with the maintenance and improvement of buildings and facilities . During a review of contract facility's policy and procedure (P&P) titled, Laundry Handling & Processing Policy, reviewed date 2/1/25, the P&P indicated, .committed to providing a safe, clean, and hygienic environment for residents, staff, and visitors in accordance with regulatory guidance and industry best practices . Washing: Adhere to (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Kingsburg Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1101 Stroud Ave Kingsburg, CA 93631	
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manufacturer's recommendation and instructions . The lip of the washer door should be disinfected prior to closing and starting the cycle . The laundry area and equipment should be routinely cleaned and disinfected . Almenar, [NAME] (40641) - RESIDENT NOTE No Notes		