STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055662	A. Building B. Wing	09/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethany Home Society San Joaquin County	930 West Main Street Ripon, CA 95366

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 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. (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure safe monitoring practices for high-risk medication (drugs with potential to cause harm without monitoring) use in one out of four residents (Resident 1) when:1. Resident 1 was prescribed metoprolol (a medication used to control heart rate and rhythm) without orders to monitor Resident 1's blood pressure or heart rate; and2. Resident 1's experienced syncopal episodes (a brief loss of consciousnesses caused by a temporary decrease in blood flow to the brain) during transfers, which were not adequately documented or addressed by the licensed nurse (LN).These failures had the potential to result in unsafe medication use and adverse consequences for Resident 1.1. Review of Resident 1's admission RECORD indicated Resident 1 was admitted to the facility with diagnoses that included but was not limited to atrial fibrillation (A-Fib; heart rhythm disorder) and hypertension (HTN; high blood pressure). During a concurrent interview and record review on 9/5/25 at 2:33 PM, Resident 1's Order Summary Report, dated 9/25 and Blood Pressure and Pulse Summary report, dated from 6/20/25 through 9/5/25, was reviewed with LN 1. LN 1 confirmed that Resident 1 had an order for .Metoprolol Succinate Oral Capsule ER [extended release] 24 Hour Sprinkle 50 MG [milligrams; a unit of measurement] (Metoprolol Succinate) Give 50 mg by mouth one time a day for A-fib. LN 1 confirmed Resident 1's metoprolol order did not include directions of when to hold or administer the medication based on the result of Resident 1's blood pressure or heart rate. LN 1 confirmed the following blood pressures (BP) and heart rate (HR) noted on Resident 1's vital summary report: 6/12/25 BP of 106/81, 6/27/25 HR of 128, 7/2/25 HR of 44, 7/4/25 HR of 113, 7/6/25 HR of 99 and BP of 99/60, 7/13/25 BP of 105/611, 7/18/25 BP of 106/70, 7/19/25 BP of 110/58, and 8/22/25 BP of 105/65. LN 1 stated that based on the review of Resident 1's blood pressures and heart rates, the results should have been reviewed with Resident 1's physician. LN 1 confirmed there was no documentation in Resident 1's electronic medical record that indicated that BP and HR results were reviewed with Resident 1's physician.During a concurrent interview and record review on 9/9/25 at 1:55 PM, Resident 1's physician order for Metoprolol Succinate, order dated 3/19/24, was reviewed with LN 2. LN 2 stated that Resident 1's physician order for the Metoprolol medication should have had parameters for blood pressure and heart rate monitoring and then, based on those parameters, the medication would then be administered or held. During a concurrent interview and record review on 9/15/25 at 3:10 PM, Resident 1's Consultant Pharmacist's Medication Regiment Review [an evaluation of a resident's entire medication list to ensure that the medication is safe, effective, and appropriate for their condition], dated 6/25, 7/25, and 8/25, were reviewed with the Pharmacy Consultant (PharmD). The PharmD stated that based on Resident 1's BP and HR results and with the history of syncope, he should have made a recommendation to the MD for Resident 1 to have daily monitoring of the blood pressure and heart rate prior to the administration of metoprolol.2. During a review of Resident 1's nurse progress notes, dated 6/26/25 and 6/27/25, indicated that Resident 1 became unresponsive while being transferred in the standing lift (a device designed to assist individual with limited mobility in going from a seated to a standing position) on 6/26/25 and 6/27/25.During an interview on 9/9/25 at 1:33 PM with Certified Nursing Assistant (CNA) 1, CNA 1 stated, Almost every time I work with [Resident 1], [Resident 1] becomes dizzy and lightheaded when I move [Resident 1] from a lying to sitting position or from sitting to standing using the standing lift. CNA 1 continued to state that Resident 1 must be sat back down or laid back down on the bed for fear that Resident 1 was going to pass out. CNA 1 stated that she did not always report these episodes to the licensed nurse (LN) because sometimes the episodes came and went very quickly.During a concurrent interview and record review on 9/5/25 at 2:33 PM, Resident 1's NURSES NOTE, dated 6/27/25, was reviewed with LN 1. LN 1 stated that Resident 1 had a history of syncopal episodes that occurred while in the standing lift. LN 1 confirmed there was no documentation that indicated that Resident 1 was assessed for orthostatic hypotension (form of low blood pressure that might cause dizziness, lightheadedness, or fainting when rising from sitting or lying down) or the possibility of completing orthostatic blood pressures (checking the BP and HR while lying, sitting, and standing) was discussed with Resident 1's physician. During an interview on 9/9/25 at 1:55 PM, LN 2 stated that Resident 1 did have a history of syncopal episodes that may be related to a drop in Resident 1's blood pressure or pulse from the Metoprolol medication. LN 2 stated that the licensed nurse should have initiated orthostatic blood pressures and heart rate checks after Resident 1's syncopal episode so that a more detailed and thorough report could have been given to Resident 1's physician.During a concurrent interview and record review on 9/9/25 at 4:04 PM with LN 3, Resident 1's NURSES NOTE, dated 6/27/25 was reviewed with LN 3. LN 3

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to revise the restorative nursing program (RNP-nursing intervention to increase or maintain resident's mobility and to prevent further decline in mobility) for one of four sampled residents (Resident 1) when the RNP plan of care for passive range of motion (PROM - the movement of a joint through the range of motion with no effort from the patient) exercises to Resident 1's upper extremities was not revised following a right shoulder dislocation and fracture.This failure placed Resident 1 at risk for further injury, pain and discomfort to the right shoulder and right arm.Findings:During a review of Resident 1's admission RECORD, indicated that Resident 1 was admitted to the facility with diagnoses that included but were not limited to dementia (a decline in mental ability severe enough to interfere with daily life), displaced fracture of upper end of right humerus (arm bone), and unspecified dislocation of right shoulder (when the ball shaped head of the humerus bone (upper arm) comes out of the socket in the shoulder blade).During a review of Resident 1's physician orders, dated 9/25, the following orders were indicated as active orders . (R) [right] Shoulder Dislocation: CHECK for IMMOBILIZER [a type of arm sling used to hold the arm against the body, restricting movement of the shoulder and upper arm to promote healing from injuries like dislocation and fracture] PLACEMENT: Monitor for swelling, tenderness, numbness, tingling, discoloration and circulation. every shift for Dislocation.RA [restorative assistant] for Passive ROM to upper and lower extremities three times weekly as tolerated. During a concurrent interview and record review on 9/8/25 at 2:29 PM Resident 1's RNP order and the recorded Restorative Nursing Assistant (RNA) documentation to the upper and lower extremities three times a week as tolerated was reviewed with RNA 1. RNA 1 confirmed that Resident 1 received treatment from the RNA on the following dates: 7/1/25, 7/3/25, 7/6/25, 7/8/25, 7/10/25, 7/13/25, 7/15/25, 7/20/25, 7/22/25, 7/24/25, 7/27/25, 7/29/25, 7/31/25, 8/26/25, 8/28/25, 8/31/25, 9/4/25 and 9/7/25. RNA 1 confirmed that for the month of July of 2025 and for the period from 8/26/25 through 9/7/25, there was no documentation in Resident 1's electronic medical record that indicated that the PROM exercises to Resident 1's right upper arm was held. RNA 1 stated that the RNP order should have reflected that exercises to the right upper arm were not to be done and that the immobilizer was to remain in place except for bathing and dressing. During a concurrent interview and record review on 9/5/25 at 3:53 PM Resident 1's RNP meeting agenda, RNP care plan, and the RNP order were reviewed with the Director of Staff Development (DSD). The DSD stated that part of the DSD duties included overseeing the RNP which included updating the MD and physical therapist for order initiation of a RNP or revision of the current RNP and any need for physical or occupational therapy screening. The DSD stated that Resident 1's RNP had last been reviewed by the RNP team on 6/5/25 and no changes in Resident 1's plan were recommended at that time. The DSD confirmed that Resident 1's RNP had not changed and that the RNP for Resident 1 was not reviewed in the RNP meeting that was held in July or August of 2025 when Resident 1 returned from the acute hospital on 7/2/25 with the new diagnoses of dislocation of the right shoulder and fracture of the right humerus. The DSD stated that Resident 1 should have been referred to physical therapy for screening. The DSD stated that not updating the RNP for Resident 1 so that PROM to the right upper extremity was excluded, placed Resident 1 at risk for further injury, pain and discomfort. The DSD further stated that there had been no training on the immobilizer placement or techniques in positioning and transferring Resident 1 to avoid further injury. The DSD stated that providing that type of training to the Certified Nursing Assistants (CNA) and RNAs would have been beneficial to prevent further pain or injury to Resident 1.During an interview on 9/5/25 at 3:59 PM, the Director of Rehabilitation (DOR) stated that Resident 1 had not been screened by physical therapy when Resident 1 was readmitted from the acute hospital on 7/2/25 with new diagnoses of right shoulder dislocation and right humorous fracture. The DOR further stated that the physical therapist should have screened Resident 1's mobility, reassessed Resident 1's ordered RNP, and provided education to the CNAs and RNAs to ensure they were able to properly place the right arm immobilizer.During a concurrent interview and record review on 9/5/25 at 3:53 PM, Resident 1's physician order for the immobilizer to the right arm, dated 7/7/25, and Resident 1's RNP order for PROM to the upper and lower extremities three times weekly as tolerated, dated 2/25/20, were reviewed with the Director of Nurses (DON). The DON stated that since the immobilizer was on Resident 1's right arm, the expectation was that the RNAs would know not to perform the PROM exercises or to remove the immobilizer even though Resident 1's RNP order had not been updated upon Resident 1's return from the acute hospital on 7/2/25. The DON further stated that updating the RNP order to