STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055935	A. Building B. Wing	04/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ceres Postacute Care	1711 Richland Avenue Ceres, CA 95307

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47254 Based on interview and record review, the facility failed to ensure licensed nurses assessed and provided interventions in accordance with professional standards of practice as outlined in the comprehensive care plan for one of four residents (Resident 1), when Resident 1 did not receive a complete and accurate initial wound assessment on readmission (4/25/2024) and did not have weekly wound monitoring, assessments and wound measurements for Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9) from 4/25/2024 to 5/9/2024 and licensed nurses did not assess, measure and notify a physician of changes to wound #8 and wound #9 from 5/9/2024 to 6/27/2024. These failures resulted in an avoidable necrotic (death of cells or tissue through disease or injury) wounds to Resident 1's lower extremities which included Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9) wounds; and resulted in an admission to a general acute care hospital (GACH) on 7/14/2024 for sepsis (a serious condition in which the body responds to an infection) related to left foot necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin) that required surgical amputation (the removal by surgery of a limb because of injury) on 7/15/2024 to Resident 1's left lower extremity . Findings: During a review of Resident 1's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was readmitted from the hospital to the facility on [DATE]. Resident 1 has a history that includes but not limited to end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), diabetes type II (high levels of sugar in the blood) chronic pain syndrome (persistent pain), atrial fibrillation (an irregular and often very rapid heart rhythm), unspecified dementia (symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning), and chronic obstructive pulmonary disease (disease causing restricted airflow and breathing problems). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 9 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating moderate cognitive impairment. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a record review of Resident 1's Progress Nurses Note, dated 4/25/2024, the Progress Nurses Note indicated, Licensed Vocational Nurse (LVN) 1 . notified Resident 1's primary physician via phone regarding Resident 1's readmission (4/25/2024) and made aware regarding skin issues . Primary physician provided phone orders to .monitor skin discolorations .[times] 14 days and reassess . There was no documentation in the Progress Nurses Note to indicated nursing staff identified wound #8 and wound #9 individually to the primary physician. During a record review of Resident 1's Wound Evaluation & Management Summary, dated 5/9/2024, the Wound Evaluation & Management Summary indicated, Wound Physician 1 identified wound #8 .Unstageable (Due to Necrosis) of the left [inner] ankle .wound size .1.0x2.0 centimeter [cm- units of measurement] surface area 2.00 cm .Duration [greater than] 35 days . 100% thick adherent black necrotic tissue .Wound #9 . Unstageable (Due to Necrosis) of the right [outer] ankle .wound size .1.5x1.0 centimeter surface area 1.5 cm . Duration [greater than] 35 days .100% thick adherent black necrotic tissue . During a concurrent interview and record review on 3/21/2025 at 12 :10 p.m., with the Administrator (ADM), Resident 1's electronic medical records , Nursing Admission Assessment and Wound Evaluation & Management Summary, dated 4/25/2024 to 7/14/2024 were reviewed. The ADM stated Resident 1's wound # 8 and wound #9 could not have developed necrosis (death of cells or tissue through disease or injury) from the time they were identified as discoloration on the Nursing Admission assessment dated [DATE], to the Wound Physician 1 assessment Wound Evaluation & Management Summary dated 5/9/2024. The ADM stated on 4/25/2024 discoloration was documented by LVN 1 regarding Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9); the ADM stated that LVN 1 did not document wounds. The ADM stated on 5/9/2024 Wound Physician 1 documented Resident 1 had a left inner ankle wound (#8) and right outer ankle wound (#9). The ADM was not able to explain how Resident 1 was assessed to have necrotic wounds per the Wound Physician note of 5/9/25 and that LVN 1 should have identified more than discoloration on the initial readmission assessment on 4/25/2024. (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 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 3/21/2025 at 1:35 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's Nursing Admission Assessment (NAA, dated 4/8/2024 and 4/25/2024 was reviewed. The NAA, dated 4/8/2024, indicated Resident 1's right outer ankle (wound #9) had a scab (a dry, rough protective crust that forms over a cut or wound during healing) measuring 10.5 centimeters (cm-unit of measurement) x 11.5 cm and residents left inner ankle (wound #8) was documented to have a popped blister measuring 15cm x 9 cm. The NAA indicated, on 4/25/2024, Resident 1 was admitted with left inner ankle discoloration (wound #8) and right foot discoloration (wound #9) no measurements were taken on 4/25/2024. LVN 1 stated his initial assessment of Resident 1 on 4/25/2024 indicated left inner ankle and right outer ankle discoloration and that these areas were not documented as wounds. LVN 1 stated he did not consider the discolored areas, wounds at the time of readmission on 4/25/2024. LVN 1 stated he did not review descriptions of wound #8 and wound #9 documented in previous facility records for Resident 1. LVN 1 stated facility licensed nurses do not stage wounds, only describe them in progress nursing notes. LVN 1 stated the facility NAA defines wound staging for skin assessments. LVN 1 stated as an example on Resident 1's prior admission on 4/8/2024 the popped blister would be considered a stage II pressure injury. LVN 1 stated only the facility wound physician stages wounds. LVN 1 stated nurses have not had wound training. LVN 1 stated he did not ask the Director of Nurses (DON) for guidance when assessing Resident 1's skin on 4/25/2024. LVN 1 stated nurses are responsible for accurate resident assessments. LVN 1 stated in his clinical judgement, he appropriately documented Resident 1's left inner ankle as discoloration and the right outer ankle as discoloration, and he did not consider those areas wounds. LVN 1 stated the facility has never taken any pictures of wounds, and the nurses are responsible for daily skin assessments and notification to the primary physician if there are any skin changes. LVN 1 stated he was aware of Wound Physician 1's assessment of Resident 1's necrotic wounds #8 and #9 on 5/9/2024 and stated he believed his description of discoloration was accurate. During a record review of Resident 1's Hospital Discharge records, dated 4/25/2024, the Hospital Discharge records indicated active routine continuous wound care orders signed 4/18/2024, .Paint all foot ulcer s (an open sore on an external or internal surface of the body, caused by a break in the skin or mucous membrane) with betadine and allow to air dry [twice a day] . (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 3/21/2025 at 2:10 p.m., with LVN 1, Resident 1's Hospital Discharge records, dated 4/25/2024 was reviewed. LVN 1 stated he was not aware of any wound care treatments being conducted in the hospital prior to Resident 1's readmission to the facility on [DATE]. LVN 1 stated Resident 1was not continued on hospital wound care on 4/25/2024. LVN 1 stated he was the admission nurse for Resident 1 on 4/25/2024, and it is the admission nurse's responsibility to review and transcribe all incoming discharge orders from the hospital. LVN 1 stated he did not review, transcribe or follow up with active hospital discharge wound orders for Resident 1 upon admission on 4/25/2024. LVN 1 stated during his head-to-toe skin assessment he did not identify the left inner or right outer ankle as wounds, so no wound treatments were obtained. LVN 1 stated in his clinical judgment he believed his assessment was accurate on 4/25/2024 and stated necrosis would not develop from 4/25/2024 to 5/9/2024. LVN 1 stated failure to follow orders and assess and monitor residents accurately could cause harm or injury to residents. LVN 1 stated clinically, nurses have the knowledge to assess and stage wounds, but facility DON instructed licensed nursing staff not to stage wounds. LVN 1 stated licensed nursing staff along with certified nursing staff (CNA) should be monitoring each residents' skin daily while providing care. LVN 1 stated there was no documentation by nursing staff of changes to Resident 1's ankles from admission on 4/25/2024 until Wound Physician 1 identified wound #8 and #9 on 5/9/2024. LVN 1 was aware of Physician Wound 1's assessment of necrotic wounds on 5/9/2024 and could not explain how that could have occurred. LVN 1 stated the necrotic wounds assessed by Wound Physician 1 were in the same location as the discoloration that he documented on 4/25/2024 During a concurrent interview and record review on 3/21/2025 at 2:48 p.m., with the Director of Staff Development (DSD), Resident 1's Wound Evaluation and Management Summary , dated 5/9/2024 was reviewed. The Wound Evaluation and Management Summary indicated, Wound Physician 1 identified, measured and treated ankle wounds (#8 & #9) and indicated wounds were unstageable due to necrosis. The DSD stated per documentation, the ankle wounds to the outer right ankle (wound # 9) and inner left ankle (wound #8) went untreated and unmeasured from 4/25/2024 to 5/9/2024 and were not measured or assessed from 5/9/2024 to 6/27/2024. The DSD stated the Interdisciplinary Team (IDT- group of health care professionals with various areas of expertise who work together to meet the resident's goals) meetings are conducted for pressure wounds and there was no IDT meetings held for wound #8 and #9. The DSD stated there was no IDT meetings conducted because nursing staff did not identify wounds #8 and #9. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 3/21/2025 at 4:17 pm, with the Director of Nurses (DON), the DON stated facility staff have had wound education and clinical nurses should be capable of assessing wounds appropriately during skin assessment. The DON stated the facility is not allowed to photograph wounds, the wound physician is the only individual measuring wounds, providing treatment plans and recommendations for residents. The DON stated Resident 1's wounds # 8 and #9 were not documented as wounds and were instead documented as discoloration during nursing admission assessment on 4/25/2024. The DON stated the licensed nurse (LVN 1) assessed the resident inaccurately during the readmission skin assessment on 4/25/2024 and should have known the difference between discoloration and necrosis. The DON stated the facility nursing staff were not competent during the assessment and care of the wounds for Resident 1 between 4/25/2024 and 6/27/2024. The DON indicated facility nursing staff failed to assess and treat Resident 1's ankles (wounds #8 and 9) from 4/25/2024 until identified by the Wound Physician 1 on 5/9/2024. The DON stated the IDT team would not have reviewed the discoloration because the facility did not consider discoloration as a wound. The DON stated once identified on 5/9/2024 by Wound Physician 1, no additional wound assessment by the wound physician were conducted until 6/27/2024 when Wound Physician 2 assessed, measured and provided an updated treatment plan for Resident 1's necrotic ankle wounds (#8 and #9). The DON stated licensed nurses did not assess, measure and notify a physician of changes to wound #8 and wound #9 from 5/9/2024 to 6/27/2024. The DON stated it was her expectation that all licensed nursing staff should have been measuring wounds weekly. The DON stated the facility did not have a wound physician from 5/9/2024 to 6/27/2024. The DON stated the facility does not have designated wound nurses and charge nurses are responsible for wound treatments of their residents. The DON stated nursing staff failed to follow protocols for wound policy and procedures indicating accurate assessment, measurement and description of all wounds. The DON stated facility nursing staff failed their job description and their responsibility to ensure the plan of care was followed and the needs of the resident were met. The DON stated nursing staff failed to assess wounds on admission and then failed to monitor wounds #8 and #9 once identified by a Wound Physician 1 on 5/9/2024. The DON stated there were no updates provided to the primary physician. The DON stated the potential risk for Resident 1 due to the lapse in care and the lack of monitoring of the wounds could have potentially led to an amputation of lower extremities. During a concurrent interview and record review on 4/4/2025 at 9:15 a.m., with the DON, Resident 1's Nursing Admission Assessment, dated 4/8/2024 to 7/14/2024 were reviewed. The DON stated on the NAA dated 4/8/2024 had documentation indicating Resident 1's right ankle had a dry scab measuring 10.5 cm x 11.5cm and left inner ankle had a popped blister measuring 15cm x 9 cm. DON then stated Resident 1 had a hospitalization from ,d+[DATE]-[DATE] and upon readmission the NAA dated 4/25/2024, the NAA indicated Residents 1 left inner ankle and right outer ankle were documented as discoloration by the admitting nurse LVN 1. The DON stated LVN 1 should have reviewed previous wound notes during Resident 1's readmission on 4/25/2024 in order to identify prior recorded wounds indicated in NAA dated 4/8/2024. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 4/4/2025 at 9:45 a.m., with the DON, Resident 1's electronic medical records , Wound Evaluation & Management Summary and Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated 4/8/2024 to 7/14/2024 were reviewed. The DON stated Wound Physician 1 identified and measured wounds on 5/9/2024. The DON stated the next physician assessment of wound #8 and #9 were not conducted until 6/27/2024. The DON stated licensed nursing staff failed to measure wounds #8 and #9 weekly from 5/9/2024 to 6/27/2024 as indicated in Pressure Ulcers/Skin Breakdown- Clinical Protocol policy and procedure. The DON stated documentation did not indicate measurements of wounds #8 and #9 in the weekly skin summary assessments or progress notes. The DON stated her expectations were that staff follow wound treatments ordered by the physician and track progress which includes wound measurements needed to communicate to the resident's primary physician. The DON stated all licensed nursing staff have the clinical knowledge to follow wound treatments and to take measurements of wounds. DON stated licensed nursing staff have been instructed to describe wounds but not stage any wounds. During a record review of the Resident 1's general acute care hospital (GACH) Consult Note , dated 7/14/2024, the Consult Note indicated, .the foot and ankle team has been consulted for the treatment of necrotizing infection of the medial (means toward the middle or center) rear foot and ankle on the left lower extremity .When informed that the patient may need debridement (the removal of damaged tissue) did reach out the family to discuss my concerns with the lower extremity .Patient has multiple wounds of the bilateral lower extremities with more concerning being the medial ankle of the left foot . Boggy (feeling of sponginess in the tissue) appearance noted to the medial ankle wound on the left leg with necrotic center in a circular ulceration deep and probing to the bone. Slight malodor (a very unpleasant smell) noted from the area with the surrounding erythema (reddening of the skin) to the left ankle including the heel . During a record review of Resident 1's GACH Post-Op (after surgery) Note dated, 7/15/2024, the Post-Op Note indicated, .Pre-operative (before surgery) diagnosis: Septic shock (complication of sepsis)[and] Left foot gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) .Procedure . Left guillotine (all of the tissues from the skin to the bone are cut at the level of the ankle) [below the knee] . Description .[surgical instrument] was used to amputate the distal (furthest part of the body) left lower extremity below the knee . During a review of the facility policy and procedure (P&P) titled, Competency of Nursing Staff dated [DATE], the P&P indicated, .licensed nurses and nursing assistants employed by the facility will . demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care .competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as . basic nursing skills .skin and wound care .infection control . identification of changes in condition . Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge . During a review of the facility policy and procedure (P&P) titled, Resident Examination and assessment dated [DATE], the policy and procedure indicated, .Review the residents admission assessment and/or preliminary care plan to assess for any special situations regarding the resident' care .Physical exam .skin . intactness .moisture .color .texture .presence of bruises, pressure ulcers, redness, edema, rashes . Documentation .all assessment data .notify the physician of any abnormalities . wounds or rashes on the residents skin . (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol dated [DATE], the policy and procedure indicated, .The nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length and depth, presence of exudates and necrotic tissue .the staff .will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions .During resident visits, the physician will evaluate and document the progress of wound healing- especially for those with complicated, extensive, or poor-healing wounds . During a review of the facilities job description manual titled, Licensed Vocational Nurse dated 10/19/2015, the job description indicated, . Job skills . comprehensive knowledge of nursing principles required, including the ability to recognize and identify symptoms and manager emergency situations .collect, reports and documents objective and subjective data .contributes to establishing individualized patient goals . implements the plan of care . evaluates effectiveness of intervention's to achieve patient goals and minimize re-hospitalization . administers medication and performs treatments per physician orders . documents accurately and thoroughly . consults and seeks guidance from RN as necessary During a review of the facilities Wound Physicians [name of company] Wound Service Agreement dated and signed 2/7/2023, the agreement indicated, . [name of company] shall .document the patient status and wound care needs and include specific dressing orders .provide education to the wound care nurse and/or facility personnel on wound treatments .

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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 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47254 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) received treatment and care in accordance with professional standards of practice when Resident 1 did not receive a complete and accurate initial wound assessment on readmission (4/25/2024) and did not have weekly wound monitoring, assessments and wound measurements for Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9) from 4/25/2024 to 5/9/2024 and licensed nurses did not assess, measure and notify a physician of changes to wound #8 and wound #9 from 5/9/2024 to 6/27/2024. And Resident 1 did not have a comprehensive person-centered care plan (an individual summary of a person's health conditions, specific care needs, and current treatments) for wounds #8 and #9. These failures resulted in no individual care plan for the avoidable necrotic (death of cells or tissue through disease or injury) wounds to Resident 1's lower extremities which included Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9) wounds; and resulted in an admission to a general acute care hospital (GACH) on 7/14/2024 for sepsis (a serious condition in which the body responds to an infection) related to left foot necrotizing fasciitis (a serious bacterial infection that destroys tissue under the skin) that required surgical amputation (the removal by surgery of a limb because of injury) on 7/15/2024 to Resident 1's left lower extremity . Findings: During a review of Resident 1's Admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 1 was readmitted from the hospital to the facility on [DATE]. Resident 1 has a history that includes but not limited to end stage renal disease (a condition in which the kidneys lose the ability to remove waste and balance fluids), anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues), diabetes type II (high levels of sugar in the blood) chronic pain syndrome (persistent pain), atrial fibrillation (an irregular and often very rapid heart rhythm), unspecified dementia (symptoms that negatively affect memory, thinking, and social abilities severely enough to interfere with daily functioning), and chronic obstructive pulmonary disease (disease causing restricted airflow and breathing problems). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], Resident 1's MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 9 out of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating moderate cognitive impairment. During a record review of Resident 1's Progress Nurses Note, dated 4/25/2024, the Progress Nurses Note indicated, Licensed Vocational Nurse (LVN) 1 . notified Resident 1's primary physician via phone regarding Resident 1's readmission (4/25/2024) and made aware regarding skin issues . Primary physician provided phone orders to .monitor skin discolorations .[times] 14 days and reassess . There was no documentation in the Progress Nurses Note to indicated nursing staff identified wound #8 and wound #9 individually to the primary physician. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a record review of Resident 1's Wound Evaluation & Management Summary, dated 5/9/2024, the Wound Evaluation & Management Summary indicated, Wound Physician 1 identified wound #8 .Unstageable (Due to Necrosis) of the left [inner] ankle .wound size .1.0x2.0 centimeter [cm- units of measurement] surface area 2.00 cm .Duration [greater than] 35 days . 100% thick adherent black necrotic tissue .Wound #9 . Unstageable (Due to Necrosis) of the right [outer] ankle .wound size .1.5x1.0 centimeter surface area 1.5 cm . Duration [greater than] 35 days .100% thick adherent black necrotic tissue . During a concurrent interview and record review on 3/21/2025 at 12 :10 p.m., with the Administrator (ADM), Resident 1's electronic medical records, Nursing Admission Assessment and Wound Evaluation & Management Summary, dated 4/25/2024 to 7/14/2024 were reviewed. The ADM stated Resident 1's wound # 8 and wound #9 could not have developed necrosis (death of cells or tissue through disease or injury) from the time they were identified as discoloration on the Nursing Admission assessment dated [DATE], to the Wound Physician 1 assessment Wound Evaluation & Management Summary dated 5/9/2024. The ADM stated on 4/25/2024 discoloration was documented by LVN 1 regarding Resident 1's left inner ankle (wound #8) and right outer ankle (wound #9); the ADM stated that LVN 1 did not document wounds. The ADM stated on 5/9/2024 Wound Physician 1 documented Resident 1 had a left inner ankle wound (#8) and right outer ankle wound (#9). The ADM was not able to explain how Resident 1 was assessed to have necrotic wounds per the Wound Physician note of 5/9/25 and that LVN 1 should have identified more than discoloration on the initial readmission assessment on 4/25/2024. During a concurrent interview and record review on 3/21/2025 at 1:35 p.m., with Licensed Vocational Nurse (LVN) 1, Resident 1's Nursing Admission Assessment (NAA, dated 4/8/2024 and 4/25/2024 was reviewed. The NAA, dated 4/8/2024, indicated Resident 1's right outer ankle (wound #9) had a scab (a dry, rough protective crust that forms over a cut or wound during healing) measuring 10.5 centimeters (cm-unit of measurement) x 11.5 cm and residents left inner ankle (wound #8) was documented to have a popped blister measuring 15cm x 9 cm. The NAA indicated, on 4/25/2024, Resident 1 was admitted with left inner ankle discoloration (wound #8) and right foot discoloration (wound #9) no measurements were taken on 4/25/2024. LVN 1 stated his initial assessment of Resident 1 on 4/25/2024 indicated left inner ankle and right outer ankle discoloration and that these areas were not documented as wounds. LVN 1 stated he did not consider the discolored areas, wounds at the time of readmission on 4/25/2024. LVN 1 stated he did not review descriptions of wound #8 and wound #9 documented in previous facility records for Resident 1. LVN 1 stated facility licensed nurses do not stage wounds, only describe them in progress nursing notes. LVN 1 stated the facility NAA defines wound staging for skin assessments. LVN 1 stated as an example on Resident 1's prior admission on 4/8/2024 the popped blister would be considered a stage II pressure injury. LVN 1 stated only the facility wound physician stages wounds. LVN 1 stated nurses have not had wound training. LVN 1 stated he did not ask the Director of Nurses (DON) for guidance when assessing Resident 1's skin on 4/25/2024. LVN 1 stated nurses are responsible for accurate resident assessments. LVN 1 stated in his clinical judgement, he appropriately documented Resident 1's left inner ankle as discoloration and the right outer ankle as discoloration, and he did not consider those areas wounds. LVN 1 stated the facility has never taken any pictures of wounds, and the nurses are responsible for daily skin assessments and notification to the primary physician if there are any skin changes. LVN 1 stated he was aware of Wound Physician 1's assessment of Resident 1's necrotic wounds #8 and #9 on 5/9/2024 and stated he believed his description of discoloration was accurate. (continued on next page)

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Ceres Postacute Care	1711 Richland Avenue Ceres, CA 95307

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a record review of Resident 1's Hospital Discharge records, dated 4/25/2024, the Hospital Discharge records indicated active routine continuous wound care orders signed 4/18/2024, .Paint all foot ulcers (an open sore on an external or internal surface of the body, caused by a break in the skin or mucous membrane) with betadine and allow to air dry [twice a day] . During a concurrent interview and record review on 3/21/2025 at 2:10 p.m., with LVN 1, Resident 1's Hospital Discharge records, dated 4/25/2024 was reviewed. LVN 1 stated he was not aware of any wound care treatments being conducted in the hospital prior to Resident 1's readmission to the facility on [DATE]. LVN 1 stated Resident 1was not continued on hospital wound care on 4/25/2024. LVN 1 stated he was the admission nurse for Resident 1 on 4/25/2024, and it is the admission nurse's responsibility to review and transcribe all incoming discharge orders from the hospital. LVN 1 stated he did not review, transcribe or follow up with active hospital discharge wound orders for Resident 1 upon admission on 4/25/2024. LVN 1 stated during his head-to-toe skin assessment he did not identify the left inner or right outer ankle as wounds, so no wound treatments were obtained. LVN 1 stated in his clinical judgment he believed his assessment was accurate on 4/25/2024 and stated necrosis would not develop from 4/25/2024 to 5/9/2024. LVN 1 stated failure to follow orders and assess and monitor residents accurately could cause harm or injury to residents. LVN 1 stated clinically, nurses have the knowledge to assess and stage wounds, but facility DON instructed licensed nursing staff not to stage wounds. LVN 1 stated licensed nursing staff along with certified nursing staff (CNA) should be monitoring each residents' skin daily while providing care. LVN 1 stated there was no documentation by nursing staff of changes to Resident 1's ankles from admission on 4/25/2024 until Wound Physician 1 identified wound #8 and #9 on 5/9/2024. LVN 1 was aware of Physician Wound 1's assessment of necrotic wounds on 5/9/2024 and could not explain how that could have occurred. LVN 1 stated the necrotic wounds assessed by Wound Physician 1 were in the same location as the discoloration that he documented on 4/25/2024. During a concurrent interview and record review on 3/21/2025 at 2:20 p.m., with LVN 1, Resident 1's Care Plan Report, dated 4/25/2024 was reviewed. LVN 1 stated right foot and left ankle were identified as discoloration and not wounds, and interventions were for staff to monitor for signs and symptoms of infection and notify primary physician of any changes. LVN 1 stated the wounds should have been identified as wounds not discoloration on readmission. LVN 1 stated he did not assess correctly during his readmission assessment. LVN 1 stated because he did not assess Resident 1 correctly, Resident 1's care plans did not meet the needs of Resident 1. During a concurrent interview and record review on 3/21/2025 at 2:48 p.m., with the Director of Staff Development (DSD), Resident 1's Wound Evaluation and Management Summary , dated 5/9/2024 was reviewed. The Wound Evaluation and Management Summary indicated, Wound Physician 1 identified, measured and treated ankle wounds (#8 & #9) and indicated wounds were unstageable due to necrosis. The DSD stated per documentation, the ankle wounds to the outer right ankle (wound # 9) and inner left ankle (wound #8) went untreated and unmeasured from 4/25/2024 to 5/9/2024 and were not measured or assessed from 5/9/2024 to 6/27/2024. The DSD stated the Interdisciplinary Team (IDT- group of health care professionals with various areas of expertise who work together to meet the resident's goals) meetings are conducted for pressure wounds and there was no IDT meetings held for wound #8 and #9. The DSD stated there was no IDT meetings conducted because nursing staff did not identify wounds #8 and #9. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 3/21/2025 at 4:17 pm, with the Director of Nurses (DON), the DON stated facility staff have had wound education and clinical nurses should be capable of assessing wounds appropriately during skin assessment. The DON stated the facility is not allowed to photograph wounds, the wound physician is the only individual measuring wounds, providing treatment plans and recommendations for residents. The DON stated Resident 1's wounds # 8 and #9 were not documented as wounds and were instead documented as discoloration during nursing admission assessment on 4/25/2024. The DON stated the licensed nurse (LVN 1) assessed the resident inaccurately during the readmission skin assessment on 4/25/2024 and should have known the difference between discoloration and necrosis. The DON stated the facility nursing staff were not competent during the assessment and care of the wounds for Resident 1 between 4/25/2024 and 6/27/2024. The DON indicated facility nursing staff failed to assess and treat Resident 1's ankles (wounds #8 and 9) from 4/25/2024 until identified by the Wound Physician 1 on 5/9/2024. The DON stated the IDT team would not have reviewed the discoloration because the facility did not consider discoloration as a wound. The DON stated once identified on 5/9/2024 by Wound Physician 1, no additional wound assessment by the wound physician were conducted until 6/27/2024 when Wound Physician 2 assessed, measured and provided an updated treatment plan for Resident 1's necrotic ankle wounds (#8 and #9). The DON stated licensed nurses did not assess, measure and notify a physician of changes to wound #8 and wound #9 from 5/9/2024 to 6/27/2024. The DON stated it was her expectation that all licensed nursing staff should have been measuring wounds weekly. The DON stated the facility did not have a wound physician from 5/9/2024 to 6/27/2024. The DON stated the facility does not have designated wound nurses and charge nurses are responsible for wound treatments of their residents. The DON stated nursing staff failed to follow protocols for wound policy and procedures indicating accurate assessment, measurement and description of all wounds. The DON stated facility nursing staff failed their job description and their responsibility to ensure the plan of care was followed and the needs of the resident were met. The DON stated nursing staff failed to assess wounds on admission and then failed to monitor wounds #8 and #9 once identified by a Wound Physician 1 on 5/9/2024. The DON stated there were no updates provided to the primary physician. The DON stated the potential risk for Resident 1 due to the lapse in care and the lack of monitoring of the wounds could have potentially led to an amputation of lower extremities. During a concurrent interview and record review on 4/4/2025 at 9:15 a.m., with the DON, Resident 1's Nursing Admission Assessment, dated 4/8/2024 to 7/14/2024 were reviewed. The DON stated on the NAA dated 4/8/2024 had documentation indicating Resident 1's right ankle had a dry scab measuring 10.5 cm x 11.5cm and left inner ankle had a popped blister measuring 15cm x 9 cm. DON then stated Resident 1 had a hospitalization from ,d+[DATE]-[DATE] and upon readmission the NAA dated 4/25/2024, the NAA indicated Residents 1 left inner ankle and right outer ankle were documented as discoloration by the admitting nurse LVN 1. The DON stated LVN 1 should have reviewed previous wound notes during Resident 1's readmission on 4/25/2024 in order to identify prior recorded wounds indicated in NAA dated 4/8/2024. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a concurrent interview and record review on 4/4/2025 at 9:45 a.m., with the DON, Resident 1's electronic medical records, Wound Evaluation & Management Summary, Pressure Ulcers/Skin Breakdown-Clinical Protocol, and Care plan Report dated 4/8/2024 to 7/14/2024 were reviewed. The DON stated Wound Physician 1 identified and measured wounds on 5/9/2024. The DON stated the next physician assessment of wound #8 and #9 were not conducted until 6/27/2024. The DON stated licensed nursing staff failed to measure wounds #8 and #9 weekly from 5/9/2024 to 6/27/2024 as indicated in Pressure Ulcers/Skin Breakdown- Clinical Protocol policy and procedure. The DON stated documentation did not indicate measurements of wounds #8 and #9 in the weekly skin summary assessments or progress notes. The DON stated her expectations were that staff follow wound treatments ordered by the physician and track progress which includes wound measurements needed to communicate to the resident's primary physician. The DON stated all licensed nursing staff have the clinical knowledge to follow wound treatments and to take measurements of wounds. DON stated licensed nursing staff have been instructed to describe wounds but not stage any wounds. During a concurrent interview and record review on 4/4/2025 at 10 a.m., with the DON, Resident 1's Care Plan Report, dated 4/25/2024 was reviewed. The DON stated the care plans for right foot and left ankle were identified as discoloration and not wounds, and interventions included staff to monitor for signs and symptoms of infection and notify primary physician of any changes. The DON stated Resident 1's care plans did not have an accurate description of all of Resident 1 wounds. The DON verified wounds #8 and #9 were not on the care plan. The DON stated Resident 1's care plan did not meet his wound needs. During a record review of the Resident 1's general acute care hospital (GACH) Consult Note , dated 7/14/2024, the Consult Note indicated, .the foot and ankle team has been consulted for the treatment of necrotizing infection of the medial (toward the middle or center) rear foot and ankle on the left lower extremity .When informed that the patient may need debridement (the removal of damaged tissue) did reach out the family to discuss my concerns with the lower extremity .Patient has multiple wounds of the bilateral lower extremities with more concerning being the medial ankle of the left foot . Boggy (feeling of sponginess in the tissue) appearance noted to the medial ankle wound on the left leg with necrotic center in a circular ulceration deep and probing to the bone. Slight malodor (a very unpleasant smell) noted from the area with the surrounding erythema (reddening of the skin) to the left ankle including the heel . During a record review of Resident 1's GACH Post-Op (after surgery) Note dated, 7/15/2024, the Post-Op Note indicated, .Pre-operative (before surgery) diagnosis: Septic shock (complication of sepsis)[and] Left foot gangrene (death of body tissue due to a lack of blood flow or a serious bacterial infection) .Procedure . Left guillotine (all of the tissues from the skin to the bone are cut at the level of the ankle) [below the knee] . Description .[surgical instrument] was used to amputate the distal (furthest part of the body) left lower extremity below the knee . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facility policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated [DATE], the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The interdisciplinary team (IDT [team of healthcare professionals]) , in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident .The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .The comprehensive, person-centered care plan will .include measurable objectives and timeframes .incorporate identified problem areas .aid in preventive or reducing decline in the residents functional status .enhance the optimal functioning of the resident .areas of concern that are identified during the resident assessment will be evaluated before interventions are added to the care plan .Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident, are the endpoint of an interdisciplinary process .Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes .When possible, interventions address the underlying source(s) of the problem area(s), not just addressing only symptoms or triggers .The nurse and/or the interdisciplinary team must review and update the care plan . During a review of the facility policy and procedure (P&P) titled, Competency of Nursing Staff dated [DATE], the P&P indicated, .licensed nurses and nursing assistants employed by the facility will . demonstrate specific competencies and skill sets deemed necessary to care for the needs of the residents, as identified through resident assessments and described in the plans of care .competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as . basic nursing skills .skin and wound care .infection control . identification of changes in condition . Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge . During a review of the facility policy and procedure (P&P) titled, Resident Examination and assessment dated [DATE], the policy and procedure indicated, .Review the residents admission assessment and/or preliminary care plan to assess for any special situations regarding the resident' care .Physical exam .skin . intactness .moisture .color .texture .presence of bruises, pressure ulcers, redness, edema, rashes . Documentation .all assessment data .notify the physician of any abnormalities . wounds or rashes on the residents skin . During a review of the facility policy and procedure (P&P) titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol dated [DATE], the policy and procedure indicated, .The nurse shall describe and document/report the following: Full assessment of pressure sore including location, stage, length and depth, presence of exudates and necrotic tissue .the staff .will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions .During resident visits, the physician will evaluate and document the progress of wound healing- especially for those with complicated, extensive, or poor-healing wounds . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During a review of the facilities job description manual titled, Licensed Vocational Nurse dated 10/19/2015, the job description indicated, . Job skills . comprehensive knowledge of nursing principles required, including the ability to recognize and identify symptoms and manager emergency situations .collect, reports and documents objective and subjective data .contributes to establishing individualized patient goals . implements the plan of care . evaluates effectiveness of intervention's to achieve patient goals and minimize re-hospitalization . administers medication and performs treatments per physician orders . documents accurately and thoroughly . consults and seeks guidance from RN as necessary During a review of the facilities Wound Physicians [name of company] Wound Service Agreement dated and signed 2/7/2023, the agreement indicated, . [name of company] shall .document the patient status and wound care needs and include specific dressing orders .provide education to the wound care nurse and/or facility personnel on wound treatments . During a review of professional reference from the National Library of Medicine titled, Patient Safety and Quality: Chapter 12 Pressure Ulcers: A patient Safety Issue, dated April 2008, the professional reference indicated .The nurse should assess and stage the pressure ulcer at each dressing change. Experts believe that weekly assessments and staging of pressure ulcers (an open sore on an external or internal surface of the body, caused by a break in the skin or mucous membrane) will lead to earlier detection of wound infections as well as being a good parameter for gauging of wound healing Most experts agree that when a pressure ulcer develops its location, size (length, width, and depth), and color of the wound; amount and type of exudate (serous(producing serum), sangous (bloodred), pustular (pus-filled); odor; nature and frequency of pain if present (episodic [short amount of time] or continuous); color and type of tissue/character of the wound bed, including evidence of healing (e.g., granulation tissue) (new connective tissue that develop at the wound site in the process of healing) or necrosis(death of cells or tissue through disease or injury) (slough (yellow devitalized tissue)or eschar (a dry, dark scab or falling away of dead skin); and description of wound edges and surrounding tissue (e.g., rolled edges, redness, hardness/induration, maceration(A softening and breaking down of skin resulting from prolonged exposure to moisture) should be assessed and documented. Upon identifying the ulcer characteristics, the initial stage of the should be completed .