

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055935	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/28/2026
NAME OF PROVIDER OR SUPPLIER Ceres Postacute Care		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Based on observation, interview, and record review, the facility failed to provide Physical Therapy (PT - a healthcare specialty that aims to improve and restore physical function, reduce pain, and prevent future injuries) treatment and services to increase range of motion (the full movement potential of a joint to flex and extend in any direction) and mobility (the ability to move, change, or control their body position independently and comfortably) to prevent further decrease in range of motion and mobility for one of three sampled residents (Resident 1), when Resident 1 was not provided PT treatment and services on 4/13/26, 4/14/26, and 4/15/26. This failure had the potential to result in further decrease in range of motion and mobility by reducing Resident 1's ability to walk or perform activities of daily living (dressing, toileting, bathing, feeding, and transferring) independently. Findings: During a concurrent observation and interview on 4/28/26 at 11:22 a.m. in Resident 1's room, Resident 1 was sitting up in bed. Resident 1 was alert and oriented to self, place, and time. Resident 1 stated he was unable to walk. Resident 1 stated he gained a lot of weight over the years and his legs have become weak. Resident 1 stated he wanted to lose weight and gain strength back to his legs so he could start walking again. Resident 1 stated he was supposed to receive PT treatment and services five times a week but has been going to PT only twice a week. Resident 1 stated he has been making progress with PT but was not getting as much PT as he should. Resident 1 stated he would like to go to PT every day if he could. During a review of Resident 1's admission Record (AR), dated 4/28/26, the AR indicated, Resident 1 had a history of Chronic Respiratory Failure with Hypoxia (a long-term condition where the lungs cannot adequately transfer oxygen into the blood, leading to consistently low blood oxygen levels), Abnormal Gait (walking) and Mobility, Morbid Obesity (a severe and chronic disease characterized by an accumulation of excessive body fat that poses a risk to health), Metabolic Encephalopathy (brain dysfunction caused by chemical imbalances, systemic illnesses, or organ failure), Osteoarthritis (a chronic, degenerative joint disease characterized by the progressive breakdown of cartilage - the slippery tissue cushioning joint ends) of the left and right knee, and Muscle Weakness. During a review of Resident 1's Minimum Data Set (MDS - process for clinical assessment of all residents of long term care nursing facilities), dated 4/14/26, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS - an assessment of a resident's ability to remember, concentrate, learn new things, and/or make decisions that affect their everyday life) score was 14 (a score of 0 to 7 indicated severe impairment, 8 to 12 indicated moderate impairment, and 13 to 15 indicated minimal to no impairment). The MDS indicated Resident 1 was dependent (helper does all the effort) with transfer from bed to chair and required assistance with dressing and personal hygiene (habits to maintain cleanliness). During a review of Resident 1's PT Recert, Progress Report & Updated Therapy Plan (PTR), dated 4/22/26 - 5/21/26, the PTR indicated, .STG [short term goal] Goal #3 - Continue: Pt [patient] will be able to ambulate [walk] at par bars [parallel bars - a rehabilitation tool consisting of two long, adjustable, and stable horizontal handrails] at tolerated distance with MAX A [maximum assistance] with reduced risk for falling. LTG [long term goal] Goal #3 - Continue: Pt will be able to ambulate on level surface for 75 ft [feet] using FWW [front wheel walker - device used to assist with walking] with SBA [stand by assistance]. Justification for (continued on next page)</p>

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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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Continued Skilled Services: .Continued PT services are necessary in order to facilitate independence with all functional mobility. Plan of Treatment. Frequency: 5 time(s)/week. Potential for Achieving Rehab Goals: Patient demonstrates good rehab potential as evidenced by active participation with plan of treatment.During a concurrent interview and record review on 4/28/26 at 12:09 p.m. with the Physical Therapist Assistant (PTA), Resident 1's Service Log Matrix (SLM), dated 4/1/26 - 4/30/26 was reviewed. The SLM indicated Resident 1 did not receive PT treatment and services on 4/13/26, 4/14/26, and 4/15/26. The PTA stated Resident 1 received PT treatment and services on 4/13/26 but the treatment and services were not billed (process for submitting treatments and services for reimbursement) therefore the treatment and services did not appear on the SLM. The PTA stated Resident 1 was scheduled to receive PT treatment and services on 4/14/26 but did not receive PT treatment and services on 4/14/26. The PTA stated Resident 1 was not scheduled to receive PT treatment and services on 4/15/26 and did not receive PT treatment and services on 4/15/26. The SLM stated Resident 1 was required to receive PT treatment and services five days a week according to Resident 1's PTR and did not.During a concurrent interview and record review on 4/28/26 at 12:30 p.m. with the PTA, Resident 1's Daily Activity Schedule (DAS), dated 4/13/26 was reviewed. The PTA stated the DAS indicated Resident 1 was on the schedule to receive PT treatment and services. The PTA stated Resident 1 received PT treatment and services on 4/13/26 but it was not billed.During a concurrent interview and record review on 4/28/26 at 12:35 p.m. with the PTA, Resident 1's Daily Treatment Log (DTL), dated 4/13/26 was reviewed. The PTA stated the DTL indicated Resident 1 was not on the DTL. The PTA stated the DTL indicated the PT treatment and services was supposed to be provided on 4/13/26 but Resident 1 was not on the DTL.During a concurrent interview and record review on 4/28/26 at 12:37 p.m. with the PTA, Resident 1's DAS, dated 4/14/26 was reviewed. The PTA stated the DAS indicated Resident 1 was on the schedule to receive PT treatment and services. The PTA stated Resident 1 was scheduled to receive PT treatment and services on 4/14/26 but Resident 1 did not receive PT treatment and services on 4/14/26.During a concurrent interview and record review on 4/28/26 at 12:39 p.m. with the PTA, Resident 1's DTL, dated 4/14/26 was reviewed. The PTA stated DTL indicated Resident 1 was not on the DTL. The PTA stated the DTL indicated the PT treatment and services was supposed to be provided on 4/14/26 but Resident 1 was not on the DTL.During a concurrent interview and record review on 4/28/26 at 12:42 p.m. with the PTA, Resident 1's DAS, dated 4/15/26 was reviewed. The DAS indicated Resident 1 was not on the schedule to receive PT treatment and services. The PTA stated Resident 1 was not scheduled to receive PT treatment and services on 4/15/26 and Resident 1 did not receive PT treatment and services on 4/15/26.During a concurrent interview and record review on 4/28/26 at 12:45 p.m. with the PTA, Resident 1's DTL, dated 4/15/26 was reviewed. The DTL indicated Resident 1 was not on the DTL. The PTA stated the DTL indicated the PT treatment and services provided on 4/15/26 and Resident 1 was not on the DTL.During an interview on 4/28/26 at 1:45 p.m. with the Physical Therapist (PT), the PT stated PT treatment and services were provided to Resident 1 on 4/13/26 but he was unable to recall why the treatment and services were not billed. The PT stated if the treatment and services were not billed, the treatment and services will not appear on the SLM. The PT stated if PT treatment and services were required and the treatment and services were not provided, a valid reason was required. The PT stated Resident 1 was not on the schedule to receive PT treatment and services on 4/14/26 and 4/15/26 and Resident 1 did not receive PT treatment and services on 4/14/26 and 4/15/26. The PT was unable to recall why Resident 1 was not on the DAS for 4/14/26 and 4/15/26. The PT stated if a resident was not on the DAS, the PT was unable to touch the resident. The PT stated if a regular resident was not on the DAS, rehabilitation staff should follow up with why the resident was not on the DAS. The PT stated PT treatment and services should be documented, billed, and processed in a timely manner to reflect the treatment and services provided. The PT stated missing three days of PT treatment and services was not acceptable. The PT stated missing three days of treatment was not significant but if (continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>treatment and services continued to be missed, it had the potential to set back the resident's rehabilitative progress. The PT stated the rehabilitation department had no direct supervision on the floor currently and he was only available per diem (day by day). The PT stated the facility did not have a full time Director of Rehabilitative Services (DOR) and the DOR was responsible to ensure the DAS was completed. The PT stated if a regular resident was not on the DAS, it was his responsibility to find out the reason why the resident was not scheduled and document the reason. The PT stated Resident 1 was a regular PT resident and required PT treatment and services 5 times week. The PT stated he should have questioned why Resident 1 was not on the DAS on 4/14/26 and 4/15/26 and he did not. During an interview on 4/28/26 at 2:05 p.m. with the DOR, the DOR stated Resident 1's 4/13/26 treatment and services progress note should be billed within 24 hours as a standard of practice. The DOR stated it was the DOR, the Rehabilitative Aide, and the PT's responsibility to ensure residents were seen and met their PT treatment and services frequency as planned. The DOR stated the PT had access to the assignment board and the PT indicated on Resident's 1 progress note the day before to continue plan of care five times a week. The DOR stated the assignment board was mapped out weeks in advance. The DOR stated lack of documentation indicated treatment and services were not provided. The DOR stated if a resident missed a treatment and service, the PT could back fill the treatment and service on a Saturday or Sunday. The DOR stated audits (a systematic examination and verification of records, processes, or financial accounts to ensure accuracy, compliance, and efficiency) were completed weekly to ensure residents met their frequency for PT treatment and services. The DOR stated missed treatment and services could slow rehabilitative progress. During an interview on 4/28/26 at 2:20 p.m. with the Director of Nursing (DON), the DON stated PT treatment and services should meet the resident's frequency. The DON stated missed treatment and services could cause a decline in the resident's rehabilitative progress. The DON stated it was standard of practice to document, upload and bill treatment and services in a timely manner to indicate the treatment and services were provided. The DON stated three missed treatments in a row for Resident 1 was unacceptable without a valid reason. During an interview on 4/28/26 at 2:25 p.m. with the Administrator (ADM), the ADM stated PT treatment and services should meet the resident's frequency. The ADM stated missing treatment and services could cause a decline in the resident's rehabilitative progress. The ADM stated documentation for the treatment and services were required in timely manner to reflect the care provided. The ADM stated the DOR provided oversight at two facilities and the facility was in the process of hiring a full-time and permanent DOR. During a review of the facility's policy and procedure (P&P) titled, Specialized Rehabilitative Services, dated 1/2026, the P&P indicated, POLICY: Our facility will provide rehabilitative services to residents as indicated by the MDS. PROCESS: 1. In addition to rehabilitative nursing care, the facility provides specialized rehabilitative services by qualified professional personnel. 2. Specialized rehabilitative services include the following: a. Physical therapy. Once a resident has met his/her care plan goals, a licensed professional can either discontinue treatment or initiate a maintenance program which either nursing or restorative aides will implement to assure that the resident maintains his/her functional and physical status.</p>		