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	05/16/2025

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post the results of the most recent survey in a place readily accessible for 41 of 41 residents, families, and their legal representatives. This failure had the potential to violate the rights of residents and their representatives to be informed of previous survey deficiencies. Findings: During an observation on 5/12/25 at 10:35 a.m., the facility's survey binder was located in a holder on the wall, next to the main entrance in the facility. The binder did not contain recertification results for the facility's last survey on 5/23/24. During a concurrent interview and record review on 5/16/25 at 9:01 a.m. with the Senior [NAME] President of Clinical Operations (SCO) and the Administrator (ADM), the facility's Survey Results binder, undated was reviewed. The SCO stated the previous years survey results were not included in the Survey Results binder. The ADM stated the previous year's survey results were not included in the binder. The ADM stated a staff member took out the survey results and never returned it. The ADM stated the binder should always have the survey results readily available. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated 8/09, the P&P indicated, . 1. Federal and state laws guarantee certain basic right to all residents of this facility. These rights include the resident's right to: . w. examine survey results .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, interview and record review the facility failed to ensure the accuracy of assessments for one of one sampled residents (Resident 10) when they did not accurately assess the condition of an area of excoriation (injury to the skin caused by scratching or wearing away the surface) on Resident 10's left buttock. This failure to assess Resident 10's left buttock resulted in an inability to monitor the progression of the condition- and determine if it was improved or had worsened. Findings: During a review of Resident 10's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 1/09/25, the AR indicated Resident 10 has a history of hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control) and failure to thrive (a decline caused by chronic diseases and functional impairments). During a review of Resident 10's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 10 had no cognitive impairment. During an interview on 5/12/25 at 3:12p.m. with Resident 10, Resident 10 stated he had a wound on his bottom. During a review of Resident 10's Care Plan Report (CP) dated 4/2/25, the CP indicated the focus was Resident 10 had excoriation located on left buttock. The CP indicated interventions for the left buttock area to be monitored for signs of infection. During a review of Resident 10's Treatment Administration Record (TAR) dated 5/1/25-5/31/25, the TAR indicated staff were to monitor the excoriation for signs and symptoms of infection. During a review of Resident 10's Progress Note (PN) dated 4/16/25, the PN indicated excoriation was still present upon assessment. MD notified of the condition, will continue to monitor for fourteen days. During a review of Resident 10's PN dated 4/2/25, the PN indicated the nurse reassessed Resident 10 and noted excoriation was still present. The MD was notified, and the monitoring order was renewed. During a review of Resident 10's Nursing admission Assessment (NAA) dated 1/9/25, the NAA indicated Resident 10 had excoriation to the buttock. The NAA did not indicate measurements or additional information regarding the skin condition at that time. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/15/25 at 2:41p.m. with Licensed Vocational Nurse 3 (LVN), LVN 3 stated Resident 10 had excoriation on his buttock for some time and that it was not a new issue. LVN 3 stated the assessments and documentation was to be completed in the nursing progress notes. LVN 3 stated it would have been helpful to include information on how the area of excoriation was progressing. LVN 3 stated although wound length was not typically assessed or documented by the facility staff, it would be beneficial to have a record of the progress. During an interview on 5/16/25 at 9:40p.m. with the Director of Nurses (DON), the DON stated the expectation for skin documentation included appearance, stage, measurements, progression, odor and drainage. The DON stated having documentation of the skin's appearance would be helpful in determining whether the condition had improved or worsened. During a review of Job Description: Licensed Vocational Nurse, dated 10/19/15, the LVN documents accurately and thoroughly .collects, reports and documents objective and subjective data.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview and record review, the facility failed to develop and implement person-centered care plans for two of five sampled residents (Resident 5 and Resident 9) when: 1. Resident 5 who was dependent on a wireless call light system, did not have one accessible. This failure had the potential to result in unmet personal care needs, inconsistent care and compromised dignity and safety for Resident 5; 2. Resident 9 who had been refusing snacks and meal alternatives and was on meal monitoring due to weight loss did not reciece supplimental snacks or meal alternatives. This failure had the potential to result in continued or worsening weight loss, compromised quality of life and failure to meet therapeutic goals. Findings: 1. During a review of Resident 5's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/7/25 , the AR indicated Resident 5 had the following diagnoses: Dementia (a progressive state of decline in mental abilities), muscle weakness, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from lows of depression to elevated periods of emotional highs). During a review of Resident 5's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 3/25/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function) score of five (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 5 had severe cognitive impairment. During a concurrent observation and interview on 5/12/25 at 12:28 p.m. in Resident 5's room, no call light was observed in Resident 5's room. Resident 5 stated she was unsure of the location of her call light. During a review of Care Plan (CP) dated 6/22/21, the CP for Resident 5's aggressive behavior, which included wrapping up her call light and throwing it under her bed, was in place; however, the listed interventions did not include the use of the wireless handheld call light device. During an interview on 5/14/25 at 2:03 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 Stated when a resident needed assistance, they were to use their call lights to request help. CNA 7 stated staff were responsible for being attentive and responsive to call light alerts. CNA 7 stated the risk to the residents, if a call light was not available or accessible, included falls, hunger, and unmet care needs. CNA 7 stated call lights were expected to be within the residents' reach and every resident should have had one available. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/14/25 at 2:53 p.m. with Licensed Vocation Nurse (LVN) 3, LVN 3 stated staff were alerted to residents' needs when the call lights were activated. LVN 3 stated it was essential for staff to respond in a timely manner to call lights as delays could result in serious consequences such as falls, or other adverse outcomes. During a concurrent observation and interview on 5/15/25 at 10:33 a.m. with CNA 1, CNA 1 stated that a care plan was the plan of care for a resident and that care plans were individualized based on each residents' needs. CNA 1 stated Resident 5 did not have a cord call light because she preferred using the handheld wireless device. CNA 1 stated anything could happen if a resident did not have access to a call light. CNA 1 stated a call light was essential in helping staff meet residents' needs. CNA 1 stated since Resident 5 had a specific preference of call light, it should have been reflected in the care plan. During a concurrent interview and record review on 5/15/25 at 10:54 a.m. with LVN 2, LVN 2 stated Resident 5 had a history of hiding the corded call light. LVN 2 stated Resident 5 used the handheld wireless call light, which was typically hung on her wheelchair. LVN 2 stated this method of call for assistance should have been included in her care plan to inform all staff of how Resident 5 requested assistance. LVN 2 stated Resident 5 had been using the wireless call light system for over a month. LVN 2 stated care plans needed to be resident-specific to ensure staff were aware of each resident's individual needs and the appropriate interventions. During an interview on 5/16/25 at 9:40 a.m. with the Director of Nursing (DON), the DON stated her expectation was for Resident 5 to have a care plan addressing the use of her handheld call light. During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated, the comprehensive, person-centered care plan will maintain the residents highest practicable physical, mental and psychosocial well-being .incorporate identified problem areas .incorporate risk factors associated with identified problems .reflect the residents expressed wishes regarding care and treatment goals .when possible, interventions address the underlying sources of the problem areas, not just addressing only symptoms or triggers. 2. During a review of Resident 9's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/7/25 , the AR indicated Resident 9 had the following diagnoses: muscle wasting (weakening, shrinking and loss of muscle), and protein-calorie malnutrition (when someone doesn't eat enough food with energy and protein, making them weak, tired and more likely to get sick). During a review of Resident 9's Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/6/25, the MDS section C indicated, Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 99 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 9 was unable to complete the interview. During a review of Resident 9's Medication Review Report (MRR), dated 5/15/25, the MRR indicated Resident 9 had an active order to monitor episodes of eating less than 75% of meals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 9's Medication Administration Review (MAR), dated 5/1/25-5/15/25, the MAR indicated, in the month of May, Resident 9 consumed more than 75% of her meals on only two occasions: Dinner on 5/13/25, and lunch on 5/15/25. During a review of Resident 9's Progress Notes (PN), dated 4/29/25, the PN indicated Resident 9 ate 60% of her dinner. Staff offered an alternative three times, but Resident 9 refused each offer. During a review of Resident 9's Progress Notes (PN), dated 5/1/25, the PN indicated Resident 9 ate 55% of her dinner. Staff offered an alternative three times, but Resident 9 refused each offer. During a review of Resident 9's Progress Notes (PN), dated 5/4/25, the PN indicated Resident 9 ate 50% of her dinner. Staff offered an alternative three times, but Resident 9 refused each offer. During a review of Resident 9's Progress Notes (PN), dated 5/7/25, the PN indicated Resident 9 ate 55% of her dinner. Staff offered an alternative three times, but Resident 9 refused each offer. During a review of Resident 9's Progress Notes (PN), dated 5/12/25, the PN indicated Resident 9 ate 65% of her dinner. Staff offered an alternative three times, but Resident 9 refused each offer. During an interview on 5/15/25 at 10:33 a.m. with CNA 1, CNA 1 stated the care plan served as the guiding plan of care for the residents. CNA 1 stated the care plan identified the residents' problems, which varied depending on the resident's medical history. During an interview on 5/15/25 at 10:48 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated meal monitoring should have been care planned. LVN 2 stated Resident 9 was on meal monitoring and if she ate less than 75%, staff were expected to offer a snack or an alternative meal. LVN 2 stated that Resident 9 sometimes refused these offers. LVN 2 stated Resident 9 did not have a care plan in place addressing interventions for when Resident 9 refused supplements or alternatives. LVN 2 states there should have been a care plan for Resident 9. During an interview on 5/15/25 at 11:41a.m. with the Director of Nurses (DON), the DON stated there was no care plan with specific interventions in place for when Resident 9 refused alternatives or supplement meals. The DON stated interventions were scattered among other care plans. The DON stated interventions, should have been clearly defined and specific to each specific problem. During an interview on 5/16/25 at 9:40 a.m. with the DON, the DON stated it was her expectation of staff for a care plan to be in place for when Resident 9 refused alternatives and supplements. During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 1/2018, the P&P indicated, the comprehensive, person-centered care plan will maintain the residents highest practicable physical, mental and psychosocial well-being .incorporate identified problem areas .incorporate risk factors associated with identified problems .reflect treatment goals, timetables and objectives in measurable outcomes .aid in preventing or reducing decline in the resident's functional status and or functional levels .when possible, interventions address the underlying sources of the problem areas, not just addressing only symptoms or triggers.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a fall care plan for one of four sampled residents (Resident 24) when, Resident 24 had a fall on 1/3/25, a post fall assessment recommended interventions to monitor proper wearing of shoes when up walking with a front wheeled walker (FWW) and Resident 24's care plan interventions indicated for him to wear nonskid socks when up walking with a FWW. This failure had the potential to result in Resident 24 not receiving the care and services from nursing staff and the potential for subsequent falls and injury. Findings: During observation on 5/12/25 at 10:28 a.m. with Resident 24, by the door of Resident 24's room, Resident 24 was self-ambulating with the use of a walker, with upper body bending forward and both arms extended pushing the walker in front of him. Resident 24 was wearing shoes to both feet with regular socks. Resident 24 was heading towards the dining room. During a concurrent observation and interview on 5/12/25 at 4:20 p.m. with Resident 24, at the dining room, Resident 24 was sitting in a regular chair with a walker in front of him. Resident 24 was pleasant, clean and well groomed. Resident 24 stated his correct name and stated the correct location indicating he was alert and oriented times two. Resident 24 stated he needed more therapy to strengthen his legs, and stated, I appreciate any help I could get. Resident 24 stated he was wearing a brief and someone helped him for a brief change. Resident 24 stated he can put on his shoes. During a review of Resident 24's admission Record (AR), dated 1/14/25, the AR indicated, Resident 24 was admitted to the facility on [DATE] with primary diagnosis of Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced) and other diagnoses of Macular Degeneration (an eye disease that affects central vision), generalized muscle weakness abnormalities of gait (the manner of walking) and mobility. During a review of Resident 24's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/4/25, the MDS section C indicated, Resident 24 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 11, which indicated Resident 24's cognition was moderately impaired. During an interview on 5/14/25 at 2:00 p.m. with Restorative Nurse Assistant (RNA) 1, RNA 1 stated Resident 24 is receiving restorative services (are services to maintain and maximize a person's level of function). RNA 1 stated Resident 24 is on Restorative Nursing Program for ambulation. RNA 1 stated Resident 24 can walk with a walker without staff assistance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/15/25 at 10:20 a.m. with the Director of Nursing (DON), Resident 24's Electronic Medical Records (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, (undated) and Rehab Post Fall Assessment -V2 dated 1/6/25 were reviewed. The Care Plan Report, indicated, . The resident is at risk for falls related to forgetful gait balance problem. The Rehab Post Fall Assessment -V2 indicated, . 13. Recommendation will monitor proper wearing of shoes and utilization of Front-wheeled walker (FWW) for ambulation . The DON stated Resident 24 had a fall on 1/3/25 and stated Resident 24's at risk for fall care plan did not indicate new intervention (any action or measures taken to prevent a fall). The DON stated Resident 24's fall care plan should have been updated based on Rehab recommendations and interventions to reflect current intervention prevent further falls. The DON stated it was nurses' responsibility to update and revise the care plan , the care plan goal and interventions must be revised after the fall, and stated, . to prevent from happening again. During an observation on 5/16/25 at 8:29 a.m. with Resident 24, in Resident 24's room, Resident 24 was lying in the middle of bed asleep, with feet on the ground, wearing a shoe to his left foot and regular sock to the right foot. During a concurrent interview and record review on 5/16/25 at 8:50 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 24's fall care plan, dated 9/26/20 was reviewed. The fall care plan indicated, . The resident is at risk for falls related to forgetful gait balance problem. Interventions anticipate and meet resident's needs, ensure wearing non-skid socks when ambulating, follow facility protocol, . LVN 4 stated Resident 24 was wearing shoes when ambulating with a walker and not with non-skid socks. LVN 4 stated Resident 24 is at risk for falls and had a fall on 1/3/25. LVN 4 stated Resident 24 leans forward with walker out in front of him when ambulating, and stated, . his walker should stay closed to him to prevent falls. LVN 4 stated monitoring and reminding Resident 24 to keep his walker close to him should be included in the fall interventions. LVN 4 stated Resident 24's fall care plan should be person-centered and needs to be revised and updated to reflect the current function of Resident 24. LVN stated Resident 24's care plan should be reviewed if care plan goal was met. LVN 4 stated a care plan is very important for the staff to know how to take care of the residents to prevent and minimize the falls. During a review of facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 1/18, the P&P indicated, . Resident-centered approaches to managing falls and fall risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant .

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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 quality by not following facility's policy and procedure (P&P) for Administering Medications for two of nine sampled residents (Residents 1 and 3) when, 1. Licensed Vocational Nurse (LVN) 1 and LVN 3 used one resident identifier (name, date of birth , photograph, wrist band [containing resident information of name and date of birth for proper resident identification], and staff verification) before medication administration for Resident 1 and Resident 3. This failure had the potential for medication errors and negative drug interactions (occur when the effects of one drug are altered by another drug that can lead to decreased effectiveness of medication) for Residents 1 and Resident 3. 2. LVN 1 signed (documented medication was administered) Resident 1's Electronic Medication Administration Records (EMAR -an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident) when the inhaler medication salbutamol (medication used to treat asthma (a condition in which person's airways become inflame, narrow , and swell, and produce extra mucus, which makes it difficult to breathe) and exercise-induced bronchospasm (a life-threatening emergency that occurs when the muscles surrounding the lungs' small airways tighten, narrowing the airways) was not administered. This failure had the potential for Resident 2 not to receive the inhaler medication as prescribed by the doctor and placed Resident 2 at risk for negative outcome including shortness of breath. Findings: 1. During an observation on 5/13/25 11:43 a.m. with LVN 3, in Resident 3's room, LVN 3 stated I am your nurse, [stated resident's name]. Resident 3 did not respond when LVN 3 stated his name. LVN 3 stated she would check his gastrostomy tube (GT- a feeding tube inserted directly into the stomach through a small incision in the abdomen) placement and will administer one medication and stated, Synthroid (brand name for Levothyroxine [use to treat underactive thyroid]). Resident 3 did not look at LVN 3 while she explained the procedure to Resident 3. Resident 3 wore a wrist band (containing resident information of name and date of birth for proper resident identification) to his right wrist. LVN 3 did not check Resident 3's wrist band. LVN 3 checked GT placement with the use of stethoscope and checked gastric residual (the amount of liquid remaining in the stomach after the feeding). LVN 3 dissolved one tablet of Levothyroxine in 15 millimeters (ml- unit of measurement) of water and administered through GT via gravity. LVN 3 used one resident identifier [Resident 3's name] prior to administering the medication for Resident 3. During a review of Resident 3's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 5/15/25, the AR indicated, Resident 3 was admitted to the facility on [DATE] with a primary diagnosis of Dementia (a progressive state of decline in mental abilities), Gastrostomy Status (refers to the presence of absence of gastrostomy, which is a surgical opening into the stomach), and Hypothyroidism (a condition in which the thyroid gland doesn't produce enough thyroid hormone). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/15/25, the MDS section C indicated, Resident 3 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) was blank, which indicated, Section C -Cognitive Patterns C0100 was coded 0 No (resident is rarely/never understood). During an observation on 5/14/25 at 8:59 a.m. with LVN 1, outside Resident 1's room, LVN 1 was preparing Resident 1's medications for 7:00 a.m. and 8:00 a.m. on the top of the medication cart. During an observation on 5/14/25 at 9:02 a.m. with LVN 1, in Resident 1's room, LVN 1 put on a pair of gloves before entering Resident 1's room. LVN 1 was wearing a glove while holding a medication tray with oral medications, insulin pen, and eye drops and knocked on Resident 1's door. LVN 1 stated, Hello [stated Resident 1's first name], I will give your medications, Insulin Glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) and eyedrops. Resident 1 did not respond when LVN 1 stated Resident 1's first name. LVN 1 administered three of three medications by mouth to Resident 1 using one resident identifier [Resident 1's first name). During an observation on 5/14/25 at 9:03 a.m. with LVN 1, in Resident 1's room, LVN 1 stated, I am giving your long-acting insulin on your left arm. LVN 1 stated Resident 1's first name and injected the insulin into Resident 1's left arm. LVN 1 used one resident identifier [Resident 1's first name] prior to administering Resident 1's insulin injection. During an observation on 5/14/25 at 9:04 a.m. with LVN 1, in Resident 1's room, LVN 1 stated Resident 1's first name and instilled one drop of lubricant eye drops in the middle of both eyes. LVN 1 used one resident identifier [Resident 1's first name] prior to administering Resident 1's eye drops. During an interview on 5/14/25 9:38 a.m. with LVN 1, at the nursing station, LVN 1 stated he did not check Resident 1'swrist band and photo of Resident 1 before administering her medications. LVN 1 stated he addressed Resident 2 by her first name. LVN 1 stated it was important to check three resident identifiers including the photo and wrist band to ensure the nurses are administering medication to the right patient to prevent medication error. During an interview on 5/14/25 at 3:15 p.m. with LVN 3, at the nursing station, LVN 3 stated nurses needed to check the resident's photo, wrist band and allergies to make sure nurses are administering medication to the right resident to prevent medication error. LVN 3 stated checking two or more resident identifiers is important for non-verbal (non-speaking) and cognitively impaired residents and stated, . we need to do all the check. During an interview on 5/15/25 at 9:58 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the nurses to follow the P&P for medication administration. The DON stated nurses should use two or more resident identifiers, including resident's photo and wrist band before administering the medications. The DON stated the verification with another staff is important for non-verbal and cognitively impaired residents. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Administering Medications, dated 1/18, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. 6. The individual administering medication must verify the resident's identity before giving the resident his/her medication. Methods of identifying the residents include: a. Check identification band; b. Checking photograph attached to medical record; and c. If necessary, verifying resident identification with other facility personnel. 2. During an observation on 5/14/25 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 1, outside Resident 2's room, LVN 1 was preparing Resident 2's 8:00 a.m. medications on the top of the medication cart. LVN 1 prepared nine oral medications and placed them in 2 separate medication cups. During an observation on 5/14/25 at 8:39 a.m. with LVN 1, outside Resident 2's room, LVN 1 knocked on Resident 2's door and stated Resident 2's last name. LVN 1 informed Resident 2 the name of medications in the medication cups and administered nine oral medications to Resident 2. LVN 1 went back to the medication cart parked outside Resident 2's room and signed all 8:00 a.m. medications as administered, including Resident 2's salbutamol inhaler . LVN 1 did not administer Resident 2's inhaler. During a concurrent interview and record review on 5/14/25 at 9:38 a.m. with LVN 1, at the nursing station, LVN 1 reviewed Resident 2's EMAR, dated 5/14/25, the EMAR indicated, Albuterol Sulfate HFA Inhalation Aerosol Solution (mist that has medicine in it) 108 (90 Base) MCG/ACT (refers to the unit of measurement for drug dosage which indicates the amount of medication in a single dose from an inhaler) 2 puff inhale orally three times a day for shortness of breath at 0800 1200 1600 [4 p.m.]. LVN 1 stated he did not administer Resident 2's inhaler at 8:00 a.m. and stated, I forgot. LVN 1 stated he signed the EMAR for salbutamol inhaler during the morning medication pass and did not administer it. LVN 1 stated, I should not sign the EMAR. During an interview on 5/16/25 10:48 a.m. with the DON, the DON stated her expectation was for nurses to follow the P&P for medication administration and documentation. The DON stated nurses should not sign the EMAR if the medication was not given. The DON stated this practice can result in medication error. During a review of the facility's P&P titled, Administering Medications, dated 1/18, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. 19. The individual administering the medication must initial the resident's MAR after giving each medication.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the resident environment remains free of accident hazards (a danger or risks) as possible for one of four sampled residents (Resident 31) when, Resident 31's room was cluttered (filled with disorganized items, making it difficult to move around and find things) with multiple boxes at the back of Resident 31's room blocking the door from opening fully and the carpet on the floor had curled edges. These failures placed Resident 31 at risk for an avoidable accident including falling and fall related injuries. Findings: During a concurrent observation and interview on 5/12/25 at 11:30 a.m. with Resident 31, in Resident 31's room, Resident 31 was lying in bed facing the door, watching a movie on his personal computer. Resident 31 stated he had been at the facility for eight months and came from an acute care hospital. Resident 31 was alert and oriented times 4 (indicating correct awareness of person, places, time and event). Resident 31 requested to keep his door closed. Resident 31's room smelled of strong urine. Resident 31 had an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) bag that was covered with a privacy bag attached to the bed frame. Resident 31 stated he had a catheter to drain his urine and was being followed by a urologist (a medical doctor who specializes in the diagnosis and treatment of diseases and conditions of the urinary tract), and stated, .had a blockage. Resident 31 had a walker by the foot of the bed and stated he could walk with or without his walker. Resident 31's room was disorganized with scattered personal belongings, bedside table filled with food, and carpet on the floor with curled edges. Resident 31's door to his room was unable to fully open due to the presence of multiple boxes at the back of the door. During a review of Resident 31's admission Record (AR), dated 5/14/25, the AR indicated, Resident 31 was admitted to the facility on [DATE] with a primary diagnosis of Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and generalized muscle weakness. During a review of Resident 31's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/6/25, the MDS section C indicated, Resident 31 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 31's cognition was cognitively intact (a person's mental functions, such as thinking, remembering, and understanding, are in good shape and not impaired). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/16/25 at 8:30 a.m. with the Social Services Director (SSD), Resident 31's Electronic Medical Records (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, (undated) and Interdisciplinary Team (IDT) Care Conference, dated 4/11/25 and 1/9/25 were reviewed. The Care Plan Report and IDT Care Conference, indicated no documentation for the cluttered room. The SSD stated the IDT did not identify and discuss Resident 31's safety and health risks related to a cluttered room. The SSD stated she was aware of Resident 31's cluttered room and she had no discussion with Resident 31 about it. The SSD stated Resident 31's cluttered room was posing lots of risks for Resident 31 and stated .can be a fire risk and a fall risk. The SSD stated Resident 31 had a carpet on the floor inside his room that could be a trip hazard. During an observation on 5/16/25 at 8:47 a.m. with Resident 31, at the front entrance area, Resident 31 was ambulating without a walker, holding the indwelling catheter bag. During a concurrent interview and record review on 5/16/25 at 8:50 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 31 had a lot of personal belongings inside his room and a carpet on the floor and stated, . a trip hazard. LVN 4 reviewed Resident 31's EMR titled, Care plan Report, dated 9/29/24, the care plan report indicated, The resident is at risk for falls related to gait/balance problems, incontinence . LVN 4 stated Resident 31 used a walker when ambulating and had episodes of ambulating without assistive device. LVN 4 stated IDT was aware of the cluttered room and strong smell of urine. During an observation on 5/16/25 at 9:10 a.m. with Housekeeping Staff (HS) 1, HS 1 was observed mopping Resident 31's floor and pointed at the multiple boxes at the back of Resident 31's room. HS 1 stated Resident 31's room was always cluttered and stated, . too much things, too much food . Resident 31's door to the room was partially open. During an interview on 5/16/25 9:17 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated she was the assigned CNA for Resident 31. CNA 5 stated Resident 31 had a cluttered room, and he refused to allow staff to touch his personal belongings. CNA 5 stated there was a safety risk and stated .heavy fall risk. CNA 5 stated she reported to the nurses about Resident 31's cluttered room. During an interview on 5/16/25 at 10:35 a.m. with the Director of Nursing (DON), the DON stated Resident 31's cluttered room posted safety and health risks to Resident 31. The DON stated Resident 31's carpet on the floor was a potential trip hazard and could result in a fall. During a concurrent observation and interview on 5/16/25 at 11:34 a.m. with Resident 31, outside Resident 31's room, Resident 31 was sitting in his walker seat facing the television in his room. Resident 31's door was partially open. Resident 31 stated he asked the staff to put that tape around the floor carpet and stated . so the girls cannot trip. Resident 31 stated, . this facility is not doing anything for me. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, dated 1/18, the P&P indicated, Based on previous evaluations and concurrent data, the staff will identify the interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: . d. obstacles in footpath; 3. Medical Factors that contribute to the risk for falls include: .e. balance and gait disorders; Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure a staff member was aware of their job duties when Restorative Nurse Aide (RNA) 1 did not have a signed job description prior to her working as an RNA. This failure had the potential to cause RNA 1 to be unaware of her job duties. Findings: During an interview on 5/14/25 at 1:35 p.m. with RNA 1, RNA 1 stated she had transitioned from being a Certified Nursing Assistant (CNA) to an RNA three months ago. RNA 1 stated she did not recall signing a job description for her new role. During a concurrent interview and record review with the Director of Staff Development RNA 1's Employee Files, undated, were reviewed. The DSD stated she could not find a signed job description for RNA 1. The DSD stated whenever a staff member gets a new role, like going from a CNA to and RNA, they should have signed a job description going over their new duties otherwise they may not be fully aware of their responsibilities. During an interview on 5/15/25 at 4:11 p.m. with the Director of Nursing (DON), the DON stated RNA 1 should have signed her job description before starting her new role. The DON stated signing the new job description ensured RNA 1 was familiar with her new job duties and responsibilities. During a review of the facility's RNA Job Description, dated 10/23/25, the Job Description indicated, . Job skills . 1. Knowledge of procedures and techniques involved in administering simple treatments and providing related bedside care services . 2. Knowledge of basic medical asepsis, sterile technique and standard precautions . 3. Willingness to work rotating shifts and different units. 4. Ability to contribute to a patient-centered environment . I understand this job description and its requirements; I understand that this is not an exclusive list of the job functions and that I am expected to complete all duties as assigned; I understand the job functions may be altered by management without notice; I understand this job description in no way constitutes an employment agreement and I am an at-will employee. I certify that I am able to perform the essential functions of this position with or without reasonable accommodation .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident's drug regimen was free from unnecessary drugs for one of six sampled residents (Resident 19) when Resident 19 was administered oxycodone hydrochloride (medication used to treat intense pain) without adequate monitoring. This failure had the potential to cause Resident 19 to experience side effects such as constipation, decreased respirations, dizziness, and increased fall risk. Findings: During a review of Resident 19's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 5/15/25, the AR indicated, Resident 19 was admitted to the facility on [DATE] with a diagnosis of chronic pain syndrome (condition that causes pain which does not easily go away). During an interview on 5/12/24 at 10:30 a.m. with Resident 19, Resident 19 stated he had had a diagnosis of chronic pain which he needed to take oxycodone hydrochloride continuously for it. During a concurrent observation and interview on 5/15/25 at 10:15 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 19's Medication Administration Record (MAR), dated 5/25, and Progress Notes dated 5/15/25 were reviewed. The MAR indicated Resident 19 received oxycodone hydrochloride continuously every eight hours for chronic pain. The Progress Notes indicated no documentation was present to monitor Resident 19's side effects after taking oxycodone hydrochloride. LVN 1 stated there was nothing documented indicating Resident 19 was being monitored for potential side effects of the medication on his MAR or Progress Notes. LVN 1 stated properly documenting the monitoring for Resident 19's oxycodone hydrochloride should have been done because it helped ensure side effects such as constipation, decreased respirations, dizziness, increased fall risk were well tracked. During an interview on 5/15/25 at 3:55 p.m. with the Director of Nursing (DON), the DON stated staff were not documenting any monitoring of potential side effects of Resident 19's use of oxycodone hydrochloride. The DON stated nurses should have documented whether or not Resident 19 was experiencing side effects, otherwise staff would not know what effect the medication had on Resident 19. During a review of the facility's policy and procedure (P&P) titled, Pain assessment and management, dated 1/18, the P&P indicated, . 2. Monitor the following factors to determine if the resident's pain is being adequately controlled . c. the presence of adverse consequences or treatment . During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK482226/ titled, Oxycodone dated 2/20/24, the PR indicated, . Patients taking oxycodone require monitoring for the presence of constipation, pain relief, adverse effects, and appropriate usage .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was 5.88 % percent. There were 34 opportunities for errors and two medication errors occurred for two of nine sampled residents (Resident 1 and Resident 2) when: 1. Resident 2 did not receive the inhaler medication Salbutamol (medication used to treat asthma (a condition in which person's airways become inflame, narrow , and swell, and produce extra mucus, which makes it difficult to breathe) and exercise-induced bronchospasm (a life-threatening emergency that occurs when the muscles surrounding the lungs' small airways tighten, narrowing the airways) at the prescribed time of administration of 8:00 a.m. on 5/14/25. 2. Resident 1 did not receive the eye drops medication (Lubricant eye drops Ophthalmic [relating to or representing the eye] Solution 0.5% at the prescribed time of administration of 7:00 a.m. on 5/14/25. These failures resulted in a medication error for Resident 1 and Resident 2 and the potential for Resident 1 to experience worsening of dry eyes and Resident 2 to experience shortness of breath. Findings: 1. During an observation on 5/14/25 at 8:25 a.m. with Licensed Vocational Nurse (LVN) 1, outside Resident 2's room, LVN 1 was preparing Resident 2's 8:00 a.m. medications on the top of the medication cart. LVN 1 prepared nine of nine oral medications and placed them in 2 separate medication cups. During an observation on 5/14/25 at 8:39 a.m. with LVN 1, outside Resident 2's room, LVN 1 knocked on Resident 2's door and stated Resident 2's last name. LVN 1 informed Resident 2 the name of medications in the medication cups and administered nine of nine oral medications. LVN 1 went back to the medication cart parked outside Resident 2's room and signed Resident 2's Electronic Medication Administration Record (EMAR -an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident), indicating she had administered all 8:00 a.m. medications to Resident 2. Resident 2 had a doctor's order for an inhaler medication Salbutamol (medication used to treat asthma (a condition in which person's airways become inflame, narrow , and swell, and produce extra mucus, which makes it difficult to breathe) and exercise-induced bronchospasm (a life-threatening emergency that occurs when the muscles surrounding the lungs' small airways tighten, narrowing the airways) to be administered at 8:00 a.m. and it was not administered. During a record review of Resident 2's admission Record (AR), dated 5/15/25, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing) and Pneumonia (an infection that inflames the air sacs in one or both lungs). (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/14/25 at 9:38 a.m. with LVN 1, Resident 2's EMAR dated 5/14/25 was reviewed. The EMAR indicated, Albuterol Sulfate (brand name of Salbutamol) HFA Inhalation Aerosol Solution (mist that has medicine in it) 108 (90 Base) MCG/ACT (refers to the unit of measurement for drug dosage which indicates the amount of medication in a single dose from an inhaler) 2 puff inhale orally three times a day for shortness of breath at 0800 1200 1600 [4 p.m.]. LVN 1 stated he did not administer Resident 2's inhaler at 8:00 a.m. LVN 1 stated I forgot. LVN 1 stated he signed the EMAR indicating he administered Salbutamol inhaler during the morning medication pass and did not administer it. LVN 1 stated, I should sign the EMAR. LVN 1 stated he administered Resident 2's Salbutamol inhaler at 9:30 a.m. LVN 1 stated he did not follow the prescribed time of the administration for Resident 2's inhaler which was due at 8:00 a.m. LVN 1 stated the inhaler medication was one and a half hours late. LVN 1 stated Resident 2 had the potential risk of difficulty in breathing. During an interview on 5/16/25 at 9:26 a.m. with LVN 1 , LVN 1 stated when a medication is administered at the wrong time it was considered a medication error. LVN 1 stated he notified the doctor and family about the medication error, and staff would monitor for any change in condition for Resident 2. During an interview on 5/15/25 at 9:58 a.m. with the Director of Nursing (DON), the DON stated her expectation was for nurses to follow the Policy and Procedures (P&P) for medication administration to prevent medication error. The DON stated late administration of medication was a medication error. The DON stated nurses should follow the prescribed time of the medication administration. The DON stated nurses should call the doctor for instructions on when to give the next dose if the prescribed time is three times a day. The DON stated the time of administration will be too close for the next dose and stated, .do not know the outcome. of being too close in timing of medication administration. The DON stated the late administration of the inhaler had the potential for Resident 2 experiencing a difficulty in breathing. During a review of the facility's P&P titled, Administering Medications, dated 1/18, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribe time, .7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, . Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 5/14/25 at 8:59 a.m. with LVN 1, outside Resident 1's room, LVN 1 was preparing Resident 1's medications for 7:00 a.m. and 8:00 a.m. on the top of the medication cart. LVN 1 put on a pair of gloves before entering Resident 1's room. LVN 1 was wearing a glove while holding a medication tray with oral medications, insulin [Glargine] pen, and eye drops and knocked on Resident 1's door. LVN 1 stated, Hello stated Resident 1's first name], I will give your medications, insulin [Glargine] and eyedrops. LVN 1 did not check Resident 1's wrist band and did not check allergies before administering the medication to Resident 1. During an observation on 5/14/25 at 9:04 a.m. with LVN 1, in Resident 1's room, LVN 1 was wearing a glove, pulled Resident 1's upper lid and instilled one drop of lubricant eye drops in the middle of both eyes. During a concurrent interview and record review on 5/14/25 9:38 a.m. with LVN 1, Resident 1's EMAR, dated 5/14/25 was reviewed. The EMAR indicated, Lubricant eye drops Ophthalmic Solution 0.5% instill 1 drop to both eyes three time a day 0700 1130 1700 [5 p.m.]. LVN 1 stated based on the doctor's order, the lubricant eye drops were prescribed for dry eyes three times a day. LVN 1 stated Resident 1's eye drops medication was due at 7:00 a.m. and was administered at 9:00 a.m. LVN 1 stated Resident 1's eye drops medication was administered two hours late. LVN 1 stated he should follow the prescribed time of administration to prevent dryness of the eyes. LVN 1 stated . maybe I asked the doctor to change the time of administration. During a record review of Resident 1's admission Record (AR), dated 5/15/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnosis of Dry Eye Syndrome (a condition when your tears can't produce and adequate lubrication for your eyes). During an interview on 5/15/25 at 9:58 a.m. with the Director of Nursing (DON), the DON stated her expectation for nurses was to follow the Policy and Procedures (P&P) for medication administration to prevent medication error. The DON stated late administration of medication was a medication error. The DON stated nurses should follow the prescribe time of the medication administration. The DON stated nurses should call the doctor for instructions on when to give the next dose if the prescribed time was three times a day. The DON stated the time of administration will be too close for the next dose and stated, .do not know the outcome. of being too close in timing of medication administration. The DON stated late administration of the lubricated eye drops can cause worsening of the Resident 1's eyes. During an interview on 5/16/25 at 9:26 a.m. with LVN 1, LVN stated the wrong time of medication administration was considered a medication error. LVN 1 stated he notified the doctor and family about the medication error, and staff will monitor for any change in condition for Resident 1. During a review of the facility's P&P titled, Administering Medications, dated 1/18, the P&P indicated, Medications shall be administered in a safe and timely manner, and as prescribed . 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribe time, .7. The individual administering the medication must check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. (continued on next page)

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	05/16/2025

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, .Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications .

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure cold food storage was stored under sanitary conditions in accordance with professional standards for food service safety when refrigerator A was observed at 42 degrees Fahrenheit (F) (unit of measure for temperature) which was above the recommended safe temperature range of 32 to 40 degree F for cold food storage. This failure had the potential to contribute to the growth of foodborne pathogens (a tiny organism, like a germ, that could cause disease. Pathogens included things like bacteria, viruses and fungi) and posed a risk of foodborne illness (any illness resulting from eating contaminated/spoiled foods) symptoms which could range from nausea, vomiting, diarrhea, abdominal pain, fever, headache, and confusion to residents who received meals and nourishment from refrigerator A. During an observation on 5/12/25 at 10:18 a.m. in the kitchen, during the initial tour the temperature of refrigerator A measured at 42 degrees F. During an observation on 5/13/25 at 8:28 a.m. in the kitchen, refrigerator A's temperature was again measured at 42 degrees F. During an interview on 5/13/25 at 2:02 p.m. with Kitchen Staff (KS) 1, KS 1 stated the refrigerator should be maintained between 34- and 36-degrees F. KS 1 stated the temperature of refrigerator A fluctuated depending on how frequently the unit door was opened. During an interview on 5/14/25 at 8:29 a.m. with KS 1, KS 1 stated the refrigerator temperature was checked up to three times per day- at 5:00 a.m., in the afternoon, and during the night shift. KS 1 stated if the temperature was found to be out of range, staff were to report it to maintenance. KS 1 stated if the refrigerator remained out of temperature range for an extended period, the food could spoil. During an interview on 5/16/25 at 8:36 a.m. with Certified Dietary Manager (CDM), the CDM stated the refrigerator temperature should be maintained between 34 and 39 degrees F, allowing for a two-degree range of flexibility. The CDM stated if the temperature rose above this acceptable range, staff were expected to contact her and maintenance immediately and remove the food from the affected refrigerator. The CDM stated the failure to address temperature deviations could result in spoiled food and posed a risk for foodborne illness to residents. During a review of the facility's policy and procedure (P&P) titled, Cold Storage Temperature Monitoring and Record Keeping, dated 2023, the P&P indicated, Refrigerator temperature standards are less or equal to forty-one degrees .the goal is to keep the temperature at thirty-four - thirty-nine degrees . During a review of the facility's P&P titled, Procedure For Refrigerated Storage, dated 2023, the P&P indicated, To keep food at a specific temperature, the air temperature in the refrigerator usually must be about two degrees lower .for example, to hold chicken at forty one degrees, the air temperature must be thirty nine degrees.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow an infection prevention and control program designed to provide a safe and sanitary environment for three of the eight (Residents 1, 2 and 14) sampled residents when: 1. The facility's written policies and procedures (P&P) for infection prevention and control program (IPCP) did not include the list of communicable diseases (infectious illnesses that spreads from one person to another or from surface to a person), when and to whom possible incidents of communicable disease or infections should be reported, and COVID-19 (Coronavirus disease 2019 -an illness caused by a virus) infection prevention and control was not updated. These failures had potential risk in the development and transmission of communicable diseases and infections for all residents. 2. Certified Nursing Assistant (CNA)1 did not wear appropriate personal protective equipment (PPE- specialized clothing, equipment, and supplies worn by healthcare workers protect residents and themselves from potential infectious hazards) when she provided care to Resident 2 who was on enhanced barrier precaution (EBP- measures used in healthcare settings to prevent the spread of infections) for a wound to the left leg. This failure had the potential for CNA 1 to cause cross contamination (spread infections to other people and places) from Resident 2's left leg wound and to other residents CNA 1 came into contact within the facility, for other residents to become infected, potentially causing health complications. 3. Licensed Vocational Nurse (LVN) 1 used one pair of gloves to administer oral medication, injectable insulin glargine (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication), and eye drops to Resident 1. LVN 1 did not wash hands or apply different gloves to administer the injectable or the eye drops. This failure had the potential risk for Resident 1 to develop an eye and skin infection. 4. Resident 14's urinal (a container used to collect a urine) was hanging in the trash can with urinal's handle touching the trash. This failure had potential for causing cross contamination (spread infections to other people and places) and spread of infection to Resident 14 and other residents. Findings: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. During a concurrent observation and interview on 5/15/25 at 9:15 a.m. with LVN 1 at Nursing Station 2, LVN 1 was looking for the written P&P for IPCP binder (a set of facility's policies and procedures aimed at preventing the spread of infection) and found the binder inside the closed top cabinet. LVN 1 stated he had not checked the written P&P for IPCP binder for months. LVN 1 with the help of the Infection Preventionist (IP) were unable to locate the posting of the local health department at the nursing station. LVN 1 stated he was not aware of the local health department contact information for reporting communicable diseases. LVN 1 handed the written P&P for infection prevention and control program binder to the IP. During an interview on 5/15/25 at 10:44 a.m. with Director of Nursing (DON), the DON stated the P&P for IPCP should be reviewed. The DON stated, I am assuming every year, not sure. The DON stated she needed to check who's responsibility it was to review the P&P for IPCP. During a concurrent interview and record review on 5/15/25 at 2:59 p.m. with the IP, the IPCP binder and the written P&P's for infection control was reviewed. IPCP Binder indicated, the list of communicable diseases, when and to whom possible incidents of communicable disease or infections should be reported were not included in current written P&P for IPCP binder. The IP stated she needed to put the communicable diseases list and contact information of the local health department in the infection control (a set of procedures and policies aimed at preventing the spread of infection) binder. The IP stated the P&P for COVID 19 - Vaccine was last updated 10/6/2022. The IP stated, .it should be updated. The IP stated written P&P for IPCP was reviewed by Interdisciplinary Team (IDT) on 1/25. The IP stated she reviewed the IPCP every month. The IP stated she could not locate the date when the IDT last reviewed their current written P&P for IPCP. The IP stated it is important to review the P&P for IPCP to prevent the transmission of communicable disease, infections, and outbreaks. During an interview on 5/15/25 at 3:52 p.m. with CNA 2, CNA 2 stated she had not received an in-service (a training) about communicable diseases. CNA 2 stated she received an in-service with the IP about no gloves on hallways and no dirty linen on the floor. During an interview on 5/15/25 at 3:55 p.m. with LVN 2, LVN 2 stated she was not sure if she received training about communicable diseases. LVN 2 was not aware of where to find the P&P for Communicable Diseases. LVN 2 stated, I am not familiar, let me find out. During an interview on 5/15/25 at 4:01 p.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 did not know where to find the list of communicable diseases. RNA 1 stated she had not received training about communicable diseases. During an interview on 5/15/25 at 4:06 p.m. with CNA 3, CNA 3 stated did not know about communicable diseases and not aware where to locate the infection control P&P. CNA 3 stated she did not remember receiving a training about communicable diseases. During an interview on 5/15/25 at 4:10 p.m. with LVN 3, LVN 3 was unable to state any of the communicable diseases. LVN 3 stated she did not know where to find the P&P for communicable diseases, and stated, I'll find out. During an interview on 5/16/25 at 11:31 a.m. with CNA 4, CNA 4 stated he did not know there was a list of communicable diseases and did not know where to access it. CNA 4 stated he was not familiar with the P&P for IPCP binder. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of facility's P&P titled, Policies and Practices-Infection Control, dated 1/18, the P&P indicated, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment to help prevent and manage transmission of diseases and infections. All personnel will be trained in our infection policies and practices upon hire and periodically thereafter, including how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. 2. During a review of Resident 2's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 5/15/25, the AR indicated, Resident 2 was admitted to the facility on [DATE] with a diagnosis of chronic ulcer of left leg (a small open sore or wound generally found in the stomach or on the skin). During an observation on 5/12/25 at 11:13 a.m. outside of Resident 2's room, Resident 2's room had an EBP sign outside of his room. CNA 1 entered Resident 2's room to provide care and did not wear PPE. During an interview on 5/12/25 at 3:14 p.m. with CNA 1, CNA 1 stated she should have worn PPE when entering Resident 2's room. CNA 1 stated Resident 1 had a wound to his left leg and wearing appropriate PPE helped to prevent any cross contamination. During an interview on 5/15/25 at 10:13 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated all staff needed to wear PPE before providing care to residents on EBP. LVN 1 stated wearing proper PPE when providing care helped prevent contamination to the residents and other staff. During an interview on 5/15/25 at 3:49 p.m. with the Infection Preventionist (IP), the IP stated all staff needed to wear PPE when entering EBP rooms to provide care. The IP stated Resident 2 had a chronic ulcer in his leg and staff needed to wear gowns and gloves if they had to touch him or the wound. The IP stated proper PPE helped prevent cross contamination from occurring; cross contamination could prevent Resident 2's wound from healing. During an interview on 5/15/25 at 3:55 p.m. with the Director of Nursing (DON), the DON stated CNA 1 needed to wear PPE when providing care to Resident 2 so no cross contamination occurred. The DON stated Resident 2's wound had the potential to become infected if proper PPE was not worn. During a review of the professional reference (PR), found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html an article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds . are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply . (continued on next page)

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 05/16/2025

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During an observation on 5/14/25 at 8:59 a.m. with LVN 1, outside Resident 1's room, LVN 1 was preparing Resident 1's medications for 7:00 a.m. and 8:00 a.m. on the top of the medication cart. LVN 1 put on a pair of gloves before entering Resident 1's room. LVN 1 was wearing a glove while holding a medication tray with oral medications, insulin glargine pen, and eye drops and knocked on Resident 1's door. LVN 1 stated, Hello [stated Resident 1's first name], I will give your medications, insulin glargine and eyedrops. LVN 1 did not check Resident 1's wrist band and did not check allergies before administering the medication to Resident 1. During an observation on 5/14/25 at 9:02 a.m. with LVN 1, in Resident 1's room, LVN 1 administered three of three medications by mouth to Resident 1 using a glove to both hands. During an observation on 5/14/25 at 9:03 a.m. with LVN 1, in Resident 1's room, LVN 1 stated, I am giving your long-acting insulin [glargine] on your left arm. LVN 1 used the same gloves when injecting the insulin glargine into Resident 1's left arm. LVN 1 did not change his gloves. During an observation on 5/14/25 at 9:04 a.m. with LVN 1, in Resident 1's room, LVN 1 used the same pair of gloves when instilling one drop of lubricant eye drops to both eyes of Resident 1. LVN 1 used one pair of gloves for different routes of medication administration including oral, insulin glargine injection, and eye drops. During an interview on 5/14/25 at 9:38 a.m. with LVN 1, LVN 1 stated, I did not change my gloves before applying the eyedrops. LVN 1 stated he used one pair of gloves when administering oral, insulin injection and eyedrops medications to Resident 1. LVN 1 stated he should have changed his gloves when administering the eyedrops to both eyes of Resident 1 to prevent cross contamination and potential eye infection. During an interview on 5/15/25 at 8:32 a.m. with the IP, the IP stated nurses should follow standard precautions for medication administration. The IP stated nurses should change the gloves after oral medication administration, insulin glargine administration, and eye drops administration. The IP stated using the same pair of gloves when administering different routes of medications had the potential risk for cross contamination and infection. During an interview on 5/15/25 at 10:44 a.m. with the DON, the DON stated gloves must be changed after each route of medication administrations (oral, insulin glargine injections, and eye drops) to prevent cross contamination and potential infection to the eye and skin. During a review of facility's P&P titled, Standard Precautions, dated 1/18, the P&P indicated, Standard precautions are used in the care of all residents in all situations regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions include the following practices:2. Gloves e. Gloves are changed as necessary, during the care of a resident to prevent cross-contamination from one body site to another . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During a concurrent observation and interview on 5/12/25 at 10:28 a.m. with Resident 14, in Resident 14's room, Resident 14 was laying in bed, awake, alert and oriented times 4 (person, place, time, and event). Resident 14 was pleasant, clean, and well groomed. Resident 14 stated he's been at the facility since 2016. Resident 14 stated he was admitted to the facility from the hospital. Resident 14 stated he has a diagnosis of Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and nurses have been checking his blood sugar four times a day. Resident 14 stated he uses urinal and a brief for episode of urine leakage. Resident 14 pointed to his urinal hanging in the trash can with the urinal holder touching the trash in the trash can at bedside. Resident 14 stated he prefers hanging his urinal in the trash can because of easy access and easily available when he needs it. Resident 14 stated staff remove the trash and empty his urinal at the end of each shift. During a review of Resident 14's AR, dated 5/14/25, the AR indicated, Resident 14 was admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus, Atherosclerotic Heart Disease (a buildup of fats and other substances in and on the artery walls), and Atrial Fibrillation (irregular heartbeat). During a review of Resident 14's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 3/1/25, the MDS section C indicated, Resident 14 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15, which indicated Resident 31 was cognitively intact (a person's mental functions, such as thinking, remembering, and understanding, are in good shape and not impaired). During a concurrent observation and interview on 5/13/25 at 11:15 a.m. with LVN 3, LVN 3 stated the urinal was hanging in the trash can with trash present in the trash can, and his urinal was half full of amber colored urine. LVN 3 stated Resident 14 wanted his urinal hanging in the trash can. LVN 3 stated having the urinal in the trash can cause cross contamination and potential infection to Resident 14. LVN 3 stated nurses needed to monitor Resident 14 for infection and address in Resident 14's weekly progress notes the risk for infection. During an interview on 5/15/25 at 8:32 a.m. with the IP, the IP stated Resident 14 wanted to hang the urinal in the trash can and refused the urinal holder. The IP stated using the trash can as urinal holder can cause cross contamination and potential infection and stated, .more infection issues . The IP stated she verbally talked to the resident about the risk of infection and created a care plan. The IP stated there was no IDT meeting regarding Resident 14's use of trash can as urinal holder and how to minimize and prevent infection. During a concurrent observation and interview on 5/16/25 at 8:24 a.m. with Resident 14, in Resident 14's room, Resident 14's urinal was hanging in the trash can (with trash) at bedside. Resident 14' urinal was a quarter full of yellow colored urine. Resident 14 stated he requested to keep the urinal hanging in the trash can for easy access and easy reach. Resident 14 stated he tried the urinal holder, and he had difficulty accessing his urinal. Resident 14 stated he had been hanging his urinal in the trash can since 2016. Resident 14 stated staff changed his brief at least once a shift. Resident stated staff did not empty his urinal after he used it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 5/16/25 at 10:35 a.m. with the DON, the DON stated using a trash can as urinal holder could put Resident 14 at risk for cross contamination and infection. The DON stated emptying the urinal and trash can once a shift would not be sufficient to minimize the risk of infection. During a review of Resident 14's EMR document titled Care Plan Report dated 5/13/25, the Care Plan Report, indicated, .Risk for infection and environmental contamination related to improper storage of urinal bottle . During a review of facility's P&P titled, Standard Precautions, dated 1/18, the P&P indicated, Standard precautions are used in the care of all residents in all situations regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions include the following practices:5. Resident-Care Equipment a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation and interview during the survey period of 5/12/25 to 5/16/25, the facility failed to provide the minimum of at least 80 square feet per resident in multiple residents rooms (Rooms 1, 2, 3, 4, 5, 6, 11, 12, 13, 14, 15, 16, 17 and 18), when the amount of usable living space was not adequate for residents. This failure had the potential for residents in Rooms 1, 2, 3, 4, 5, 6, 11, 12,13, 14, 15, 16, 17 and 18 to not have reasonable privacy or adequate space. Findings: During an environmental tour with the Maintenance Supervisor (MS) and Maintenance Assistant (MA), on 05/15/25 11:09 a.m., the inspection indicated the following rooms did not meet the minimum square footage as required by regulation. However, variations were in accordance with the particular needs of the residents. The residents had a reasonable amount of privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents. These rooms were as follows: Room number(#) Square feet #Residents 1 140 2 2 140 2 3 140 2 4 (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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	140 2 5 210 3 6 210 3 11 140 2 12 140 2 13 210 3 14 210 3 15 140 2 16 (continued on next page)

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	05/16/2025

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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	140 2 17 148 2 18 168 2 Recommend waiver to be continue in effect. _____ Health Facilities Evaluator Supervisor Signature Date: