

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Keystone Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3672 North First Street Fresno, CA 93726	
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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interviews and record reviews the facility failed to meet the minimum requirement of a registered nurse (RN) on duty for eight consecutive hours per day, seven days per week when a RN was not on duty for a the minimum eight consecutive hours for 12 days in May 2026, 24 days in June 2026, and 17 days in July 2026. This failure had the potential to result in residents not receiving services required to be provided by a RN. Findings: During an interview on 7/17/26 at 9:48 a.m. with the Director of Nursing (DON), the DON stated, We had a lot of changes. The DON stated the RN went on medical leave and the facility has not hired any additional RNs. The DON stated the facility had a part-time RN, however they have not worked on the facility for more than three months The DON, stated, I do not have any RNs working on the weekend. The DON stated, It is important to have a RN on the floor for clinical practice. The DON stated RNs have full clinical practice and License Vocation Nurses practice were limited. The DON stated that when an RN is not at the facility it could cause residents to experience a delay in care and to not receive the services they need. The DON stated residents were at risk for hospitalization when they had delayed care and services. During an interview on 7/17/26 at 3:04 pm, with the Admi nistrator (ADM) the ADM stated, the facility uses an on-call list of RNs, for residents with intravenous medications. The ADM stated the facility was expected to take care of the residents. The ADM stated the DON has had to come in after hours for coverage. The ADM stated there were not any RNs currently working eight consecutive hours for the facility. The ADM stated residents were at risk for hospitalization when the an RN was not present to do full scope clinical practices. During review of the facility's staff assignment calendar titled, Nursing Staffing Assignment dated 5/2026, the calendar indicated, that there was no RN working on 5/2/26, 5/4/26, 5/5/26, 5/10/26, 5/11/26, 5/17/26, 5/18/26, 5/19/26, 5/24/26, 5/25/26, 5/30/26, 5/31/26. The facility's Nursing Staffing Assignments indicated the facility did not schedule or have a RN to care for residents for 12 days in May of 2026. During review of the facility's staff assignment calendar titled, Nursing Staffing Assignment dated 6/2026, the calendar indicated, there was no RN working on 6/1/26, 6/2/26, 6/6/26, 6/7/26, 6/8/26, 6/9/26, 6/13/26, 6/14/26, 6/15/26, 6/16/26, 6/17/26, 6/18/26, 6/19/26, 6/20/26, 6/21/26, 6/22/26, 6/23/26, 6/24/26, 6/25/26, 6/26/26, 6/27/26, 6/28/26, 6/29/26, 6/30/26 . The facility's Nursing Staffing Assignments indicated the facility did not schedule or have a RN to care for residents for 24 days in June of 2026. During the facility's staff calendar titled, Nursing Staffing Assignment dated 7/2026, the calendar indicated, no RN was working on 7/1/26, 7/2/26, 7/3/26, 7/4/26, 7/5/26, 7/6/26, 7/7/26, 7/8/26, 7/9/26, 7/10/26, 7/11/26, 7/12/26, 7/13/26, 7/14/26, 7/15/26, 7/16/26, 7/17/26. The facility's Nursing Staffing Assignments indicated the facility did not schedule or have a RN to care for residents for 17 days in July of 2026. During a review of the facility's policy and procedures (P&P) titled, Staffing, Sufficient and Competent Nursing dated 4/2024, the P&P indicated, The facility provides sufficient (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056266	Facility ID: 056266 If continuation sheet Page 1 of 28

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	numbers of nursing staff with.3.A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (7) days a week.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain an effective pest control program to eradicate and contain the presence of pests when: 1. Cockroaches were observed in the kitchen on 7/14/26 and 7/15/26. This failure had the potential to place 64 out of 65 residents receiving food from the kitchen at risk for cross-contamination when cockroaches were observed in the kitchen, and throughout the facility, since 10/23/25. 2. A fly was observed on 7/14/26 in the shared room of Resident 34 and Resident 38 and Resident 34 was holding a fly swatter. Resident 22 was observed with a fly swatter in her container for personal items on her bedside table which was positioned over her bed, and a fly was observed in the hallway between the kitchen and dining room on 7/15/26. This failure had the potential to place Resident's 22, 34 and 38 at risk of infection due to cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). Findings: During a concurrent observation and interview on 7/14/26 at 8:53 a.m. with the Certified Dietary Manager (CDM) and the Registered Dietician (RD), in the kitchen near the tray line table, a cockroach was observed on the floor crawling toward the tray line table. The CDM stated cockroaches had been observed throughout the kitchen for approximately a year, since he started. During a concurrent observation and interview on 7/15/26 at 12:12 p.m. with the CDM, in the kitchen during lunch tray line, [NAME] (CK) 1 was observed plating resident meals. A cockroach was observed on the floor crawling under the tray line table. Under the tray line table, a bug trap was observed with over 25 cockroaches, not moving. The CDM stated the facility received bug traps from pest control to help catch cockroaches. During an interview on 7/16/26 at 9:58 a.m. with Resident 3 and Resident 55, Resident 3 stated he observed a cockroach, 20 minutes prior, in the hallway crawling under the door into the kitchen. Resident 3 stated he observed cockroaches previously throughout the facility. Resident 3 stated it was, .gross., knowing cockroaches were in the kitchen where food was being stored, prepared and served. Resident 3 stated the pests were worse when and where it was hot. Resident 55 stated he observed cockroaches in the shower and throughout the facility. Resident 55 stated he felt uncomfortable knowing cockroaches were in the facility and near food in the kitchen. During a concurrent interview and record review on 7/17/26 at 9:22 a.m. with the Maintenance Director (MND), the facility's document titled, Pest Control Service Log, dated 10/23/25-7/15/26, was reviewed. The MND stated per the Pest Control Service Logs, cockroaches had been observed in the kitchen since 10/23/25. The MND stated he had observed cockroaches in the kitchen. The MND stated pest control came to the facility once a month and as needed. The MND stated it was important to adhere to facility policy and procedure to maintain an effective pest control program. The MND stated pest control was not effective if cockroaches had been present since 10/23/25. During a concurrent interview and record review on 7/17/26 at 9:52 a.m. with the RD, the facility kitchen audits titled, Dietary Sanitation/Infection Control Audit, dated 4/27/26, 5/15/26 and 6/19/26, were reviewed. The RD stated she had observed and documented cockroaches in the kitchen for 3 (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 34 was cognitively intact. During a concurrent observation and interview on 7/14/2026 at 9:35 a.m. with Resident 38, in Resident 38's room, resident 38 was observed dressed, lying in bed. Resident 38 stated she had been at the facility for one or two months due to having three wounds on her abdomen and did not want to go home without having proper treatment for her wounds first. Observed three bandages across Resident 38's abdomen with a vacuum-assisted device (wound vac &ndash; a device that pulls fluid and bacteria out of a wound to help it heal better) on the middle of her abdomen and an ileostomy (an opening (stoma) on your abdomen (belly) that connects the last part of your small intestine (ileum) to the outside of the belly) drainage bag on the right side of her abdomen, next to her wound vac dressing. Fly observed leaving the room. No questions asked regarding flies. During a review of Resident 38's AR, dated 7/16/26, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm (abnormal masses of tissue that grow and multiply) of retroperitoneum (the cavity behind the abdomen) and peritoneum (the membrane that lines the abdomen and pelvis), ileostomy, acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), neoplasm (abnormal mass of tissue) of ovary, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), perforation (a hole that goes all the way through a membrane) of intestine, and right lower quadrant (location area of the abdomen) pain. During a review of Resident 38's MDS, dated 6/7/26, the MDS section C indicated Resident 38 had a BIMS score of 14, which indicated Resident 38 was cognitively intact. During a concurrent observation and interview on 7/14/26 at 9:43 a.m. with Resident 22, in Resident 22's room, Resident 22 was observed dressed, lying in bed with her bedside table across her bed. A fly swatter was observed in a container with her other personal items on her bedside table. Resident 22 stated the Activities Director (AD) gave her the fly swatter. Resident 22 stated she had been at the facility for 11 years due to falling too much at home. Resident 22 stated she had wounds on her back side, which staff were applying a cream. Resident 22 stated there are flies in her room, mostly in the evening as well as mosquitoes. During a review of Resident 22's AR, dated 7/17/26, the AR indicated Resident 22 was admitted on [DATE] from an acute care hospital with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), kidney failure (a condition when the kidneys are unable to filter waste products from the blood), muscle wasting and atrophy (a weakening, shrinking and loss of muscle caused by disease or lack of use). During a review of Resident 22's MDS, dated 5/24/26, the MDS section C indicated Resident 22 had a BIMS score of 14, which indicated Resident 22 was cognitively intact. (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 7/15/26 at 11:31 a.m. with the AD in the hallway between the kitchen and dining room, a fly was observed flying around the AD's head and throughout the hallway. The AD stated flies came in when the outside door was opened and flies in the facility had been a problem. The AD stated there were no bug zappers or fly traps in the facility. During an interview on 7/15/26 at 3:37 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she had been at the facility since 4/28/26. CNA 1 stated she had seen flies in the facility and in residents' rooms. CNA 1 stated some residents had fly swatters in their rooms but was not sure what was being done to get rid of the flies. CNA 1 stated flies in the resident rooms were not sanitary. CNA 1 stated flies were dirty and could cause contamination of residents' items and a risk of infection for residents with wounds. CNA 1 stated there should not be flies in residents' rooms. During an interview on 7/16/26 at 8:50 a.m. with the Maintenance Director (MND), the MND stated flies barely became an issue. The MND stated he did not provide fly swatters to residents and did not know residents had fly swatters. The MND stated he was not aware of a fly problem in the facility. The MND stated flies were insects and could cause a contamination problem for the residents. The MND stated there should not be pests in the resident area. The MND stated he could only do the best of his ability to control pests. The MND stated the pest control company came once a month and was able to come to the facility more often if needed. The MND stated the current pest control program was not effective. During an interview on 7/16/26 at 11:35 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she had seen pests in the facility and informed the maintenance department of flies and roaches in the facility, in person or by entering the notation in the maintenance binder. LVN 1 stated she had only seen one resident with a fly swatter, and she kept it in a bag. LVN 1 stated it was important to keep the fly swatter in a bag to prevent infection from cross-contamination. LVN 1 stated flies were a risk for causing diseases in residents and could cause maggots. LVN 1 stated if a resident had a wound, a fly might get on the wound and worsen the wound. LVN 1 stated there should not have been flies in residents' rooms or roaches on the floor. During an interview on 7/17/26 at 2:11 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the residents to have a pest free environment. The DON stated flies could have landed on resident wounds and irritate residents. The DON stated there was a risk for infection and maggots if the flies landed on resident wounds. The DON stated staff should not have given fly swatters to residents, as there was a risk for cross contamination from the fly swatter and the residents' belongings and environment. The DON stated the pest control company came to the facility regularly and there should not have been pests in the facility. The DON stated the current pest control program was not as effective as she would like. The DON stated the facility had not reached their goal of a pest free environment as stated in the facility's policy and procedure for a pest free environment. The DON stated the pest control program was not effective at this time. During a review of the facility policy and procedure (P&P) titled, Homelike Environment, dated 2/2021, the P&P indicated, .residents are provided with a safe, clean, comfortable and homelike environment. During a review of the facility document titled, Scope of Work & Pest Control Services, dated (continued on next page)		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10/23/25, the document indicated, .to provide comprehensive pest management services that ensure a clean, safe, and pest-free environment for residents, staff, and visitors .and infection control standards applicable to healthcare facilities.additional/on-call services [as needed].fly light maintenance.mosquito reduction treatments.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review the facility failed to provide a clean, safe, and sanitary homelike environment for one of six sampled residents (Resident 32) when Resident 32's shared bathroom had a hole in the bathroom ceiling exposing white, cotton-like, dusty substance inside. This failure placed Resident 32 in an unclean, unsafe, unsanitary and non-homelike environment which could affect Resident 32's well-being. Findings: During a concurrent observation and interview on 7/14/26 at 10:25 a.m. with Resident 32, in Resident 32's room, Resident 32 was observed dressed, lying in bed. Resident 32 stated he had been in the facility for two and one-half months due to being paraplegic (paralysis-the loss of the ability to move and sometimes to feel anything on the lower half of the body) and having Clostridioides difficile (C. diff - a germ that causes an infection of the colon-the longest part of the large intestine). Resident 32 stated he did not feel the facility was being taken care of. Resident 32 complained about a hole in the bathroom ceiling, he was often hot and sweaty because the windows let the heat in, and the door handle to his room was loose. During a review of Resident 32's admission Record (AR - a summary of information regarding a resident), dated 7/17/26, the AR indicated Resident 32 was admitted to the facility from an acute care hospital on 4/2/26 with diagnoses of spinal stenosis (a narrowing of the spine that causes pressure on the spinal cord and nerves and can cause pain) lumbar (low back) and thoracic (mid-back) regions, heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), muscle weakness, kidney failure (a condition when the kidneys are unable to filter waste products from the blood), and type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high). During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool used to identify thinking, learning, understanding and physical functional level assessment), dated 6/30/26, the MDS section C indicated Resident 32 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 32 was cognitively intact. During an interview on 7/16/26 at 8:50 a.m. with the Maintenance Director (MND), the MND stated staff informed him of any repairs by verbally telling him or logging the concern in a binder at the nurses' station. The MND stated any staff can put a request in the binder and he checked the binder every day. The MND stated he performed weekly checks of resident rooms and had a log of the room temperatures. The MND stated he had no issues or complaints regarding resident rooms. The MND stated he was aware of the hole in Resident 32's bathroom ceiling but had been too busy to finish repairing it. The MND stated the air conditioner was worked on this week due to a drain that became clogged and water had drained on the bathroom ceiling of Resident 32's room. The MND stated he cut a hole in the bathroom ceiling of Resident 32's room and cleared the drain. The MND stated there should not have been a hole in the ceiling of Resident 32's bathroom. The MND stated something could have fallen from the ceiling such as insulation. The MND stated a hole in the bathroom ceiling did not create a homelike environment, especially if Resident 32 complained about it. During an interview on 7/17/26 at 2:11 p.m. with the Director of Nursing (DON), the DON stated she participated in rounds with the residents to see if they were comfortable and to address any issues. The DON stated she brought up issues with holes in the walls and resident's ceiling. The DON stated having holes in the walls and the bathroom ceiling was not a homelike environment for the residents. The DON stated her expectation was for maintenance to make repairs in a timely manner. During a (continued on next page)		

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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 observations, interviews, and record reviews, the facility failed to provide care and services in accordance with professional standards of practice for three of 12 sampled residents (Resident 2, Resident 25 and Resident 38) when:1. Resident 2 had edema (swelling caused by excess fluid trapped in your body's tissues) to the lower left extremity and no weekly progress skin assessment, change in condition and care plans were done.This failure had the potential to place Resident 2's at risk for increased edema and hospitalization.2. The physician and Resident Responsible Party (RP) were not notified when Resident 25 declined related to having their nails trimmed.This failure led to Resident 25's Responsible Party and physician to be unaware of Resident 25's refusal of treatment which placed Resident 25 at risk to attempt to perform his own nail care, possible injury, infection and hospitalization. 3. Resident 38 was not notified of the reason for the change in frequency of her pain medication from every six hours to every eight hours. There was no documentation for the change in Resident 38's pain medication frequency and no documentation of physician notification of Resident 38's increase in level of pain.This failure resulted in Resident 38 not receiving less pain medication then needed, which resulted in increased pain, reduced mobility, prolonged healing, and not having her needs met. Findings: 1. During a review of Resident 2's admission Record (AR - a summary of information regarding a patient), dated 7/17/26, the AR indicated Resident 2 was admitted to the facility from an acute care hospital on 3/14/26 with diagnoses of multiple sclerosis (MS- disorder in which the body's immune system attacks the protective covering of the nerve cells in the brain, optic nerve), muscle weakness, foot drop (symptom meaning you cannot lift the front part of your foot, which causes your toes to drag, trip, or slap the ground when you walk), personal history of venous thrombosis (is a blood clot in a vein), shortness of breath, falls and lung cancer. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [involving the process of thinking, learning and understanding] and physical functional level assessment), dated 6/13/26, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 2 had moderate cognitive impairment. During a review of Resident 2's Progress Note (PN) titled, [Name of the facility] Progress Notes dated 7/17/26, the PN indicated, On 7/14/26 at 7: 30 p.m. [Patient] Pt seen by [Nurse practitioner] at bedside today. Per [Nurse Practitioner], pt to have [Lower left edema ultrasound related to] edema. Pt to begin [furosemide] (medication given to reduce edema) 20 mg [daily] for 14 days. During an observation and interview on 07/14/2026 at 10:34 a.m. in Resident 2's room, Resident 2 was in bed with edema from on her lower left leg, her calf and foot were swollen. Resident 2's legs were not elevated, and she was lying flat on the bed. Resident 2 stated her edema to the left lower (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extremity increase but could not recall how long it had been swollen. During a concurrent interview and record review on 7/16/2026 at 12:10 p.m. with License Vocation Nurse (LVN) 1, LVN 1 stated Resident 2 did not have any wounds and edema in the PN. LVN 1 stated there was no change in condition note for Resident's 2 edema. LVN 1 stated Resident 2 did not have a weekly skin assessment. LVN 1 stated it was important to look at the skin to see if there were changes in condition. LVN 1 stated, If resident has edema, we need to be aware of it and do a change of condition. LVN 1 stated Resident 2's edema could have been a blood clot (a semi solid mass which forms in the arteries clots can be dangerous if they form inside healthy blood vessels, potentially blocking blood flow and leading to conditions like heart attacks or strokes). LVN 1 stated without the weekly skin assessment we would not know what was happening to the Resident 2's skin and could not compare it to last week. LVN 1 stated it was important to complete a change in condition regarding increased edema so that the party responsible, physician and nurse were notified. During a concurrent interview and record review on 07/16/2026 at 4:21 p.m. with LVN 4, Resident 2's weekly skin assessment documentation dated from 3/14/26-7/16/26 were reviewed . LVN 4 stated there was no complete skilled nursing weekly skin assessment summary for Resident 2 since 3/14/26. LVN 4 stated it was important to compare how the residents were doing from week to week. LVN 4 stated, Her skin issues could go unnoticed, and we could not provide proper observation which could affect her care.During a concurrent interview and record review on 07/17/2026 12:33 p.m. with LVN 4, Resident 2 PN dated 7/17/226 was reviewed. The PN indicated Resident 2 was started on furosemide (a prescription water pill, used to treat fluid retention/edema and high blood pressure) 20 milligram (mg-type of measurement) daily for lower left edema for 14 days. LVN 4 stated, Resident 2's left lower leg was considered a changed in condition and there should have been a care plan for the edema. LVN 4 stated Resident 2's care plan should have been created so nurses would follow up on the progression of the edema. LVN 4 stated a change in condition would have allowed the nursing staff to monitor the edema and the care plan would have interventions on how to care for Resident 2's edema. LVN 4 stated the edema could worsen and Resident 2 could have been hospitalized . LVN 4 stated the nurse who took the new order for medication should have done both a change in condition and created a care plan for Resident 2. During an interview on 07/17/2026 at 3:02 p.m. with the Director of Nursing (DON), the DON stated, Nurses should be doing weekly skin assessment. The DON stated the weekly skin assessment should have been done so nurses would be able to easily identify any changes in condition. The DON stated we did not follow the professional standard of practice when the nurse did not do their weekly skin assessment. The DON stated the nurse should have completed a change in condition due to the increase in edema to the lower leg and when Resident 2 started her new medication. The DON stated the nurses should monitor the edema for 72 hours when there was a change in condition. The DON stated, It was important to monitor the edema for 72 hours to see if the swelling increased or decreased and if it worsened then the nurses should have notified the physician or nurse practitioner. The DON stated the change in condition should have triggered the nurse to do a care plan. The DON stated, there should have been a care plan for Resident 2's edema. The DON stated without a care plan it causes miscommunication and inconsistent care. The DON stated Resident 2's edema could have worsened, and she could have been hospitalized . The DON stated the nurses were expected to complete a change in condition and care plan. The DON stated the nurses did not meet expectations (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and they failed to follow standard practice. During a review of the facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status dated 2/2021, the P&P indicated, .A 'significant change' of condition is a major decline or improvement in the resident's status that: A. will not normally resolved itself without intervention by staff or by implementing stated disease related clinical interventions (is not self-limiting'.requires interdisciplinary review and/or revision to the care plan and. During a review of the facility P&P titled, Resident Examination and Assessment revision dated 2/2014, the P&P indicated, The purpose of this procedure is to examine and assess the resident for any abnormalities in health status, which provides a basis for the care plan. During a review of a professional article, titled, Chapter 14 Integumentary Assessment dated 2024, retrieved from https://www.ncbi.nlm.nih.gov/books/NBK593218/#ch14integumentary.sec14.4The article indicated, Skin assessment should also be ongoing in inpatient and long-term care. A routine integumentary assessment. typically includes inspecting overall skin color, inspecting for skin lesions and wounds, and palpating extremities for edema, temperature, and capillary refill. 2. During a concurrent observation and interview on 7/14/2026 at 11:27 a.m. with Resident 25 in Resident 25's room, Resident 25 was observed dressed, sitting up in bed. Resident 25 stated he had been at the facility for 15 years because he was crazy and schizophrenic schizophrenic (a mental illness that affects a person's ability to think, feel, and behave clearly). Resident 25 stated he was not able to walk. Observed Resident 25 was missing his right leg above the knee, and his left foot was missing toes. Resident 25's right pointer fingernail was long and blackened, and his right thumbnail was jagged and cracked. Resident 25 stated staff did not have the right tool to cut his nails. Resident 25 stated the nurse took care of his nails. During a review of Resident 25's AR dated 7/16/26, the AR indicated Resident 25 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 diabetes mellitus (when the blood sugar levels in the body are too high), acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of right leg below the knee, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), schizophrenia, and acquired absence of other left toes. During a review of Resident 25's MDS section C indicated Resident 25 had a BIMS score of 13, which indicated Resident 25 was cognitively intact. During a concurrent interview and record review on 7/15/26 at 3:24 p.m. with LVN 2, Resident 25's shower log (a document that indicates if a resident received a shower, nail assessment and care, skin assessment, facial wash/shave) and is presented to the nurse for review. LVN 2 stated Resident 25 was scheduled for showers/baths on Wednesdays and Saturdays in the evening. Resident 25's shower sheet dated 7/11/26 was reviewed. The shower sheet indicated Resident 25 had a shower with no nail care or facial shave. Resident 25's shower sheet dated 7/8/26 was reviewed. The shower sheet indicated Resident 25 had a shower with nail trimming and facial trimming completed. LVN 2 stated the shower sheet had both the Certified Nursing Assistant (CNA) and LVN signatures (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating it was completed by the CNA and reviewed by the nurse. LVN 2 stated the CNAs notified nurses if a resident had dirty or long nails and did not let them clean or trim them. LVN 2 stated he was not sure why Resident 25's nails were not done. LVN 2 was shown the Resident 25's right fingernails. LVN 2 stated he was not aware of Resident 25's nail issues. LVN 2 reviewed Resident 25's Electronic Medical Chart (EMR) and stated Resident 25 had no care plan regarding long nails or refusal of nail care. LVN 2 stated there were no progress notes in Resident 25's EMR regarding his nails or if Resident 25 refused care. LVN 2 stated it was important to document if residents were refusing nail care. LVN 2 stated staff should have been documenting the monitoring of Resident 25 for of any signs or symptoms of outcomes from having long, jagged nails and to minimize danger to himself. LVN 2 stated staff needed to document long nails to protect staff in case Resident 25 lashed out with long nails during care and to be sure Resident 25's nail did not get caught on things. LVN 2 stated it was important for communication between staff and the physician for better resident outcomes and for the resident's wellbeing. During an interview on 7/15/26 at 3:37 p.m. with CNA 1, CNA 1 stated she did normal cleaning of resident nails during their shower or bath and if the resident was not diabetic, she also clipped the resident's nails. CNA 1 stated if she noticed a resident with long, jagged or dirty nails, she asked if she could clean or trim their nails. CNA 1 stated Resident 25 will refuse some care. CNA 1 stated if a resident refused care or if she saw anything out of the ordinary regarding a resident, she informed the nurse. CNA 1 stated the previous shift notified the CNAs if a resident refused showers. During an interview on 7/17/26 at 2:28 p.m. with the DON, the DON stated her expectation was for the CNAs to provide nail care during showers, unless the resident was diabetic then the nurses were to be notified and step in to provide nail care. The DON stated resident's nails should be kept up, even if the nails were long, they should be manicured. The DON stated she expected the CNAs to inform the Charge Nurses or nurses for both long nails and if the resident refused nail care. The DON stated her expectation was for the nurse to speak with resident and see if the nurse was able to give nail care. The DON stated if the resident refused nail care the nurse should have initiated a care plan for the refusal. The DON stated there should have been documentation if the resident refused nail care and if the resident wanted long nails. The DON stated staff notified the physician if the resident's long jagged nails were causing harm. The DON stated Resident 25's nails should have been addressed, and his nails could have gotten caught on items causing injury. During a review of the facility's P&P titled, Fingernails/Toenails, Care of, dated 2/2018, the P&P indicated, .the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.review the resident's care plan to assess for any special needs of the resident.stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.the following information should be recorded in the resident's medical record.any difficulties in cutting the resident's nails.if the resident refused the treatment, the reason[s] why and the intervention taken.notify the supervisor if the resident refuses the care.report other information in accordance with facility policy and professional standards of practice. During a review of the facility's P&P titled, Change in a resident's condition or Status, dated 11/2015, the P&P indicated, .our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status.the (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been refusal of treatment or medications [i.e., two [2] or more consecutive times]. a [significant change] of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff. requires interdisciplinary review and/or revision to the care plan. prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated, 3/2022, the P&P indicated, .the comprehensive, person-centered care plan. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies. 3. During a concurrent observation and interview on 7/14/2026 at 9:35 a.m. with Resident 38, in Resident 38's room, Resident 38 was observed dressed, lying in bed. Resident 38 stated she had been in the facility for one to two months due to surgery and three surgical wounds and did not want to go home without proper treatment first. Observed Resident 38's abdomen with two dressings over wounds in the middle of her abdomen and left side of her abdomen, and a colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) bag on the right side of her abdomen. Resident 38 stated she had cancer and took pain medications every eight hours. Resident 38 stated her pain medication used to be given every six hours, but the frequency was changed two days ago, and staff did not tell her why. Resident 38 stated she had let the nurse know she had cancer and had tumors that hurt. Resident 38 stated she had not heard anything more from the nurses. During a review of Resident 38's AR, dated 7/16/26, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm (abnormal masses of tissue that grow and multiply) of retroperitoneum (the cavity behind the abdomen) and peritoneum (the membrane that lines the abdomen and pelvis), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), neoplasm (abnormal mass of tissue) of ovary, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), perforation (a hole that goes all the way through a membrane) of intestine, and right lower quadrant (location area of the abdomen) pain. During a review of Resident 38's MDS, dated 6/7/26, the MDS section C indicated Resident 38 had a BIMS score of 14, which indicated Resident 38 was cognitively intact. During an interview on 7/15/26 at 3:37 p.m. with CNA 1, CNA 1 stated residents will usually tell her if they are in pain. CNA 1 stated if she noticed a resident grimacing or if the resident told her they were in pain during care, she notified the nurse. CNA 1 stated if the resident needed repositioning due to (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain, she repositioned the resident and notified the nurse. During a concurrent interview and record review on 7/16/26 at 11:35 a.m. with LVN 1, Resident 38's Medication Administration Records (MAR), dated June 2026 and July 2026 were reviewed. The MARs indicated, .oxycodone [pain medication] 10 milligrams [MG &ndash; a unit of measurement] 1 tablet every six hours as need for pain management for pain level of 6 to 10 on a scale of 1-10 for 14 days.start date on 6/5/26.discontinue date 6/9/26.oxycodone 10 MG give 1 tablet by mouth every 6 hours as needed for pain management 6-10 on a scale 1-10 for 30 days.start date 6/9/26.Oxycodone 10 MG give 1 tablet by mouth every 8 hours as needed for severe pain 6-10 for 30 days.start date 6/4/26.discontinue date 6/5/26.oxycodone 10 MG give 1 tablet by mouth every 8 hours as needed for severe pain 6-10 for 30 days.start date 7/10/26.discontinue date 7/15/26.oxycodone 10 MG 1 tablet by mouth every 6 hours as needed for pain.start date 7/15/26. LVN 1 stated the frequency of Resident 38's oxycodone was changed to every eight hours on 7/9/26 with no note regarding why the medication frequency was changed. LVN 1 stated yesterday, 7/15/26, was the first time she was notified that giving Resident 38 her pain medication every eight hours was not working. LVN 1 stated there was no documentation of why Resident 38's pain medication was originally changed to be given every eight hours and there was no documentation of physician notification of Resident 38's pain medication being given every eight hours without adequate pain relief prior to yesterday, 7/15/26. LVN 1 stated there should have been documentation for a change in medication administration, so all staff knew what was going on with Resident 38 and to monitor if Resident 38's pain medications were working. During an interview on 7/17/26 at 2:28 p.m. with the DON, the DON stated she participated in performing rounds to check on residents and make sure they were comfortable and address any needs. The DON stated her expectation for residents in pain was if a resident continued to have pain, if the pain medication was not effective or if the pain was consistent, staff should have notified the physician immediately. The DON stated there should have been progress notes documented in Resident 38's EMR indicating why changes were made in her medication administration frequency. The DON stated documentation and care plans let nurses know what the plan of care was for the residents, what implementations were to be in place and to see what worked for the residents. The DON stated she was ultimately responsible for making sure residents had safe, appropriate care. During a review of the facility's P&P titled, Change in a resident's condition or Status, dated 11/2015, the P&P indicated, .our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status.the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been.a significant change in the resident's physical/emotional/mental condition.a [significant change] of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff.prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments. During a review of the facility's P&P titled, Pain &ndash; Clinical Protocol, dated 10/2022, the P&P (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated, .the physician and staff will identify individuals who have pain or who are at risk for having pain.this includes a review for any treatments that the resident currently is receiving for pain.the nursing staff will assess each individual for pain.whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain.the nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated.the physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain.the staff will reassess the individual's pain and related consequences at regular intervals.the staff will evaluate and report the resident/patient's use of standing and as needed {PRN} analgesics.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide nail care and treatment, in accordance with professional standards of practice for one of six sampled residents (Resident 25) when Resident 25 had long, overgrown and jagged fingernails. This failure had the potential to result in Resident 25 cutting his skin with his long fingernails, leading to poor wound healing, infection, and hospitalization. Findings: During a concurrent observation and interview on 7/14/2026 at 11:27 a.m. with Resident 25 in Resident 25's room, Resident 25 was observed dressed, sitting up in bed. Resident 25 stated he had been at the facility for 15 years because he was crazy and schizophrenic (a mental illness that affects a person's ability to think, feel, and behave clearly). Resident 25 stated he was not able to walk. Observed Resident 25 was missing his right leg above the knee, and his left foot was missing toes. Resident 25's right pointer fingernail was long and blackened, and his right thumbnail was jagged and cracked. Resident 25 stated staff did not have the right tool to cut his nails. Resident 25 stated the nurse took care of his nails. During a review of Resident 25's admission Record (AR - a summary of information regarding a patient), dated 7/16/26, the AR indicated Resident 25 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of type 2 diabetes mellitus (when the blood sugar levels in the body are too high), acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of right leg below the knee, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), schizophrenia, and acquired absence of other left toes. During a review of Resident 25's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive and physical functional level assessment), dated 6/9/26, the MDS section C indicated Resident 25 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 25 was cognitively intact. During a concurrent interview and record review on 7/15/26 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 25's shower log (a document that indicates if a resident received a shower, nail assessment and care, skin assessment, facial wash/shave) and is presented to the nurse for review. LVN 2 stated Resident 25 was scheduled for showers/baths on Wednesdays and Saturdays in the evening. Resident 25's shower sheet dated 7/11/26 was reviewed. The shower sheet indicated Resident 25 had a shower with no nail care or facial shave. Resident 25's shower sheet dated 7/8/26 was reviewed. The shower sheet indicated Resident 25 had a shower with nail trimming and facial trimming completed. LVN 2 stated the shower sheet had both the Certified Nursing Assistant (CNA) and LVN signatures indicating it was completed by the CNA and reviewed by the nurse. LVN 2 stated the CNAs notified nurses if a resident had dirty or long nails and did not let them clean or trim them. LVN 2 stated he was not sure why Resident 25's nails were not done. LVN 2 was shown Resident 25's right fingernails. LVN 2 stated he was not aware of Resident 25's nail issues. LVN 2 reviewed Resident 25's Electronic Medical Chart (EMR) and stated Resident 25 had no care plan regarding long nails or refusal of nail care. LVN 2 stated there were no progress notes in Resident 25's EMR regarding his nails or if Resident 25 refused care. LVN 2 stated it was important to document if residents were refusing nail care. LVN 2 stated staff should have been documenting the monitoring of Resident 25 for of any signs or symptoms of outcomes from having long, jagged nails and to minimize danger to himself. LVN 2 stated staff needed to document long nails to protect staff in case Resident 25 lashed out with long nails during care and to be sure Resident 25's nail did not get (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caught on things. LVN 2 stated it was important for communication between staff and the physician for better resident outcomes and for the resident's wellbeing. During an interview on 7/15/26 at 3:37 p.m. with CNA 1, CNA 1 stated she did normal cleaning of resident nails during their shower or bath and if the resident was not diabetic, she also clipped the resident's nails. CNA 1 stated if she noticed a resident with long, jagged or dirty nails, she asked if she could clean or trim their nails. CNA 1 stated Resident 25 will refuse some care. CNA 1 stated if a resident refused care or if she saw anything out of the ordinary regarding a resident, she informed the nurse. CNA 1 stated the previous shift notified the CNAs if a resident refused showers. During an interview with the Infection Preventionist 1/Director of Staff Development (IP/DSD) on 7/17/2026 at 9:14 a.m., the IP 1/DSD stated CNAs can complete a form for nail care or inform the nurse or Social Services Director (SSD) if a resident needed nail care. IP 1/DSD stated her expectation was for CNAs to perform resident nail care during resident showers or when providing care to the residents and to inform nurses if a resident needed nail care. The IP 1/DSD stated if resident nail care was not completed, the resident could get a skin tear if they scratched themselves and put them at a risk for infection, especially if the resident was diabetic. During an interview on 7/17/26 at 2:28 p.m. with the Director of Nursing (DON), the DON stated her expectation was for the CNAs to provide resident nail care during resident showers or baths, unless the resident was diabetic, then the nurses were to be notified by the CNA and step in to provide the resident's nail care. The DON stated resident's nails should be kept up, even if the nails were long, they should be manicured. The DON stated she expected the CNAs to inform the Charge Nurses or nurses for both long nails and if the resident refused nail care. The DON stated her expectation was for the nurse to speak with the resident if the resident refused nail care by the CNA and see if the nurse was able to provide nail care. The DON stated if the resident refused nail care the nurse should have initiated a care plan for the refusal. The DON stated there should have been documentation if the resident refused nail care and if the resident wanted long nails. The DON stated staff notified the physician if a resident's long jagged nails were causing harm. The DON stated Resident 25's nails should have been addressed, and his nails could have gotten caught on items causing him injury. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, dated 2/2018, the P&P indicated, the purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. review the resident's care plan to assess for any special needs of the resident. stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease. the following information should be recorded in the resident's medical record. any difficulties in cutting the resident's nails. if the resident refused the treatment, the reason[s] why and the intervention taken. notify the supervisor if the resident refuses the care. report other information in accordance with facility policy and professional standards of practice. During a review of the facility's P&P titled, Change in a resident's condition or Status, dated 11/2015, the P&P indicated, our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status. the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been. refusal of treatment or medications [i.e., two [2] or more consecutive times]. a [significant change] of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff. requires interdisciplinary review and/or revision to the care plan. prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider. regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her medical care or nursing treatments.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated, 3/2022, the P&P indicated, .the comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.the resident has the right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective pain management was provided consistent with professional standards of practice and comprehensive person-centered care plan for one of six sampled residents (Resident 38) when Licensed Nurses did not address Resident 38's frequent complaints of pain after her pain medication frequency was changed. This failure resulted in Resident 38's frequent complaints of pain going unrelieved and had the potential for Resident 38's needs to be unmet and her physical well-being to go unsupported. Findings: During a concurrent observation and interview on 7/14/2026 at 9:35 a.m. with Resident 38, in Resident 38's room, Resident 38 was observed dressed, lying in bed. Resident 38 stated she had been in the facility for one to two months due to surgery and three surgical wounds and did not want to go home without proper treatment first. Observed Resident 38's abdomen with two dressings over wounds in the middle of her abdomen and left side of her abdomen, and an ileostomy (an opening on the belly that connects the last part of your small intestine to the outside of the belly) bag on the right side of her abdomen. Resident 38 stated she had cancer and took pain medications every eight hours. Resident 38 stated her pain medication used to be given every six hours, but the frequency was changed two days ago to every eight hours, and staff did not tell her why it was changed. Resident 38 stated she had informed the nurse, Social Services Director (SSD) and another staff member that she had cancer and surgery pain, and had tumors that hurt, and the change in frequency of her pain medication was not managing her pain. Resident 38 stated she had not heard anything more from the nurses or staff regarding the change. During a review of Resident 38's admission Record (AR - a summary of information regarding a resident), dated 7/16/26, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm (abnormal masses of tissue that grow and multiply) of retroperitoneum (the cavity behind the abdomen) and peritoneum (the membrane that lines the abdomen and pelvis), ileostomy, acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), neoplasm (abnormal mass of tissue) of ovary, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), perforation (a hole that goes all the way through a membrane) of intestine, and right lower quadrant (location area of the abdomen) pain. During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [involving the process of thinking, learning and understanding] and physical functional level assessment), dated 6/7/26, the MDS section C indicated Resident 38 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 38 was cognitively intact. During an interview on 7/15/26 at 3:37 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated residents usually informed her if they were in pain. CNA 1 stated if she noticed a resident grimacing or if the resident told her they were in pain during care, she notified the nurse. CNA 1 stated if the resident needed repositioning due to pain, she repositioned the resident and notified the nurse. During a concurrent interview and record review on 7/16/26 at 11:35 a.m. with LVN 1, Resident 38's Medication Administration Records (MAR), dated June 2026 and July 2026 were reviewed. The MARs indicated, .oxycodone [pain medication] 10 milligrams [MG - a unit of measurement] 1 tablet every six hours as need for pain management for pain level of 6 to 10 on a scale of 1-10 for 14 days. start date on 6/5/26. discontinue date 6/9/26. oxycodone 10 MG give 1 tablet by mouth every 6 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hours as needed for pain management 6-10 on a scale 1-10 for 30 days.start date 6/9/26.Oxycodone 10 MG give 1 tablet by mouth every 8 hours as needed for severe pain 6-10 for 30 days.start date 6/4/26.discontinue date 6/5/26.oxycodone 10 MG give 1 tablet by mouth every 8 hours as needed for severe pain 6-10 for 30 days.start date 7/10/26.discontinue date 7/15/26.oxycodone 10 MG 1 tablet by mouth every 6 hours as needed for pain.start date 7/15/26. LVN 1 stated the frequency of Resident 38's oxycodone was changed to every eight hours on 7/9/26 with no note regarding why the medication frequency was changed. LVN 1 stated yesterday, 7/15/26, was the first time she was notified that giving Resident 38 her pain medication every eight hours was not working. LVN 1 stated there was no documentation of why Resident 38's pain medication was originally changed to be given every eight hours and there was no documentation of physician notification of Resident 38's pain medication being given every eight hours without adequate pain relief prior to yesterday, 7/15/26. LVN 1 stated there should have been documentation for a change in medication administration, so all staff knew what was going on with Resident 38 and to monitor if Resident 38's pain medications were working.During a concurrent interview and record review on 7/16/26 at 11:35 a.m. with LVN 1, Resident 38's Care Plan (CP), undated was reviewed. The CP indicated, pain care plan.will voice or demonstrate via facial/body expression a level of comfort within 30 [minutes] to 1 hour after intervention[s] rendered. Will be managed through the next review date.date initiated: 6/4/26.target date: 9/20/26.identify, document and treat the resident's existing conditions which may increase pain and or discomfort.date initiated: 6/4/26.cancer careplan.resident at risk for complication as evidenced by [aeb] decrease or loss of appetite, signs or symptoms [s/s] of depression, excessive weakness, hair loss, nausea/vomiting, pain and weight loss related to: secondary malignant neoplasm of retroperitoneum and peritoneum.date initiated 7/3/26.medication as ordered.date initiated: 7/3/26. LVN 1 stated Resident 38 had a care plan for pain management, but she was not aware of Resident 38's change in medication frequency or that the frequency of her pain medication was not managing her pain until yesterday, 7/15/26.During an interview on 7/17/26 at 2:28 p.m. with the Director of Nursing (DON), the DON stated she participated in performing rounds to check on residents and make sure they were comfortable and address any needs. The DON stated her expectation for residents in pain was, if a resident continued to have pain, if the pain medication was not effective or if the pain was consistent, staff should have notified the physician immediately. The DON stated there should have been progress notes documented in Resident 38's medical record indicating why changes were made in her medication administration frequency. The DON stated documentation and care plans let nurses know what the plan of care was for the residents, what implementations were to be in place and to see what worked for the residents. The DON stated she was ultimately responsible for making sure residents had safe, appropriate care. During a review of the facility's P&P titled, Change in a resident's condition or Status, dated 11/2015, the P&P indicated, .our facility shall promptly notify the resident, his or her Attending Physician, and representative [sponsor] of changes in the resident's medical/mental condition and/or status.the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been.a significant change in the resident's physical/emotional/mental condition.a [significant change] of condition is a decline or improvement in the resident's status that: will not normally resolve itself without intervention by staff.prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider.regardless of the resident's current mental or physical condition, the Nursing Supervisor/Charge Nurse will inform the resident of any changes in his/her medical care or nursing treatments.During a review of the facility's P&P titled, Pain - Clinical Protocol, dated 10/2022, the P&P indicated, .the physician and staff will identify individuals who have (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain or who are at risk for having pain.this includes a review for any treatments that the resident currently is receiving for pain.the nursing staff will assess each individual for pain.whenever there is a significant change in condition, and when there is onset of new pain or worsening of existing pain.the nursing staff will identify any situations or interventions where an increase in the resident's pain may be anticipated.with input from the resident to the extent possible, the physician and staff will establish goals of pain treatment.the physician will order appropriate non-pharmacologic and medication interventions to address the individual's pain.the staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for acute pain or significant changes in levels of chronic pain.the staff will evaluate and report the resident/patient's use of standing and as needed [PRN] analgesics.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was stored, distributed, and served safely when the ice machine was observed with yellow, brown and black colored residue under the ice grate (a compartment within the ice machine that determines the size of the ice cubes that are produced). This failure resulted in the facility ice machine not being in a clean safe operating condition which can lead to the growth of microorganisms and result in foodborne illness for 64 out of 65 residents receiving ice at the facility. Findings: During a concurrent observation and interview on 7/14/26 at 9:18 a.m. with the Maintenance Director (MND) and the Registered Dietician (RD), in the kitchen, the ice machine was observed with yellow, brown, and black residue under the ice grate. The MND stated the discoloration was residue and should not be in the ice machine. The RD was observed wiping the residue under the ice grate with a white napkin. The yellow, brown and black residue was observed transferred from the ice grate to the white napkin. The RD stated the yellow, brown and black residue was sludge. The RD stated yellow, brown, and black sludge should not be in the ice machine because it could contaminate the ice. The RD stated ice was food and if residents ate contaminated ice, they were at risk for foodborne illness. During an interview on 7/17/26 at 9:22 a.m. with the MND, the MND stated he cleaned and sanitized the internal ice machine monthly. The MND stated the ice machine was constantly running and debris quickly built up each month. During an interview on 7/17/26 at 2:12 p.m. with the Director of Nursing (DON), the DON stated ice was food and all food was expected, according to facility policy, to be served under sanitary conditions. The DON stated the ice machine was to always be free from discoloration and/or residue to prevent contamination of ice which could result in foodborne illness if consumed. During a review of the facility's Policy and Procedure (P&P) titled, Ice Handling and Cleaning, dated 2020, the P&P indicated, .ice will be stored and served to residents in a sanitary manner. During a review of the facility's P&P titled, HACCP and Foodborne Illness, dated 2020, the P&P indicated, .common factors-according to the [Centers for Disease Control and Prevention], the following have been identified as common factors that are responsible for foodborne illness.using contaminated equipment.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 establish and maintain an effective infection prevention and control program for one of six sampled residents (Resident 38) when Resident 38 was not placed on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant bacteria that requires gown and glove use during high contact resident care activities) for her two surgical incision wounds and ileostomy (an opening on the belly that connects the last part of the small intestine to the outside of the belly) This failure placed Resident 38 at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease). Findings: During a concurrent observation and interview on 7/14/2026 at 9:35 a.m. with Resident 38, outside and inside Resident 38's room, resident 38's room was observed without an EBP sign posted on her door. There was no cart containing Personal Protective Equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) outside or inside Resident 38's room. Resident 38 was observed dressed, lying in bed. Resident 38 stated she had been in the facility for one to two months due to surgery and three surgical wounds and did not want to go home without proper treatment first. Observed Resident 38's abdomen with a vacuum-assisted device (wound vac - a device that pulls fluid and bacteria out of a wound to help it heal better) covered with a dressing in the middle of her abdomen, a dressing on the left side of her abdomen, and an ileostomy bag on the right side of her abdomen. Resident 38 stated staff did not wear a gown when they changed her dressing, they just wore gloves for her wound care. Resident 38 stated her wound VAC was changed every Monday and her other dressing changes were every three days. During a review of Resident 38's admission Record (AR - a summary of information regarding a patient), dated 7/16/26, the AR indicated Resident 38 was admitted to the facility on [DATE] with diagnoses of malignant neoplasm (abnormal masses of tissue that grow and multiply) of retroperitoneum (the cavity behind the abdomen) and peritoneum (the membrane that lines the abdomen and pelvis), ileostomy, acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), neoplasm (abnormal mass of tissue) of ovary, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), perforation (a hole that goes all the way through a membrane) of intestine, and right lower quadrant (location area of the abdomen) pain. During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [involving the process of thinking, learning and understanding] and physical functional level assessment), dated 6/7/26, the MDS section C indicated Resident 38 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 38 was cognitively intact. During an interview on 7/15/26 at 3:37 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she informed the nurse if she saw anything out of the ordinary during resident care. CNA 1 stated staff were made aware of residents with infection precautions by the signs posted on the resident's room doorway, and nurses informed the CNAs if a resident had a wound. CNA 1 stated the nurse and CNAs informed staff during shift change of resident wounds or changes in residents. CNA 1 stated staff received in-services and training on EBP. CNA 1 stated EBP was important to prevent others and self from getting infections (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and spreading it. CNA 1 stated EBP was for infection control. During an observation on 7/15/26 at 4:44 p.m. in Resident 38's room, LVN 1 was observed providing dressing changes and wound care on Resident 38. LVN 1 gathered supplies outside Resident 38's room, hand hygiene performed, gloves donned (the act of putting on) and LVN 1 informed Resident 38 of the procedure. LVN 1 disconnected Resident 38's wound vac machine from the tubing. The wound vac midline abdominal dressing was removed, the surgical wound on left abdomen's dressing was removed, and the ileostomy dressing on right abdomen was removed while wearing the same gloves. LVN removed her gloves and applied new gloves without performing hand hygiene or washing her hands prior to donning new gloves. LVN 1 removed a gauze pad from a cup with saline (a solution of salt and water) and proceeded to clean the left abdominal wound. Another gauze pad was removed from the same cup with the same gloves and Resident 38's ileostomy site was cleaned. LVN 1 then pulled another gauze from the same cup and proceeded to clean the middle wound. LVN 1 was observed pulling gauze from the same cup with saline without changing gloves or performing hand hygiene between surgical wound sites. After the sites were cleaned with the gauze, LVN 1 changed her gloves and proceeded to pull gauze from another cup of saline to wipe the skin around each site, pulling a different gauze pad from the same cup of saline without changing her gloves or performing hand hygiene after wiping each site. LVN 1 changed her glove and applied Skin Barrier using a prewrapped pad for each site. LVN 1 changed her gloves and donned new gloves without performing hand hygiene. All wound sites including the ileostomy were left open to air while LVN 1 prepared the new dressings on a bedside table. LVN 1 cut the wound vac dressing to size and the dressing for Resident 38's wound vac applied first with the edge of the dressing observed to touch the open ileostomy site and repositioned back toward the middle wound. No new gloves were applied after touching the open ileostomy site. LVN 1 proceeded to continue with the dressing application for the wound vac, left abdominal surgical site, and reapplying the ileostomy bag. During a concurrent interview and record review on 7/16/26 at 11:35 a.m. with LVN 1, Resident 38's Order Summary Report (OSR), dated 7/16/26 was reviewed. LVN 1 stated Resident 38 had no orders for EBP. Resident 38's Care Plan (CP), undated was reviewed. LVN 1 stated there was no CP for EBP during high contact care for Resident 38. LVN 1 stated Resident 38 was not on EBP. LVN 1 stated she had been the Wound Nurse for two to three months and was aware of what EBP was and what PPE were required. LVN 1 stated the Infection Prevention Nurse (IP) educated staff about infection prevention and EBP through in-services. LVN 1 stated if a resident had wounds, catheters, drains, or an ostomy the resident should have been on EBP. LVN 1 stated if a resident was on EBP a gown and gloves needed to be worn for high contract resident care. LVN 1 stated staff had huddles before each shift, and there were alert charting binders, and the resident's dashboard in the electronic system to notify staff if a resident was on EBP. LVN 1 stated the Admissions Director (ADMS) let nurses know if a resident coming to the facility needed to be on isolation precautions before the nurses got report. LVN 1 stated she asked if Resident 38 was to be on EBP and was told Resident 38 did not need to be on EBP, but she was unable to remember who gave her this information. LVN 1 stated Resident 38 should have been on EBP to protect Resident 38 from any germs during care and to protect her from cross-contamination from her roommate. During a concurrent interview and record review on 7/16/26 at 2:04 p.m. with IP 1 and IP 2, Resident 38's Electronic Medical Record (EMR) was reviewed. IP 1 stated if the facility was getting a new admit who needed infection precautions, IP 1 reviewed the reports and gave an in-service to staff on the type of infection the resident had and what PPE were required during care. IP 1 stated she performed audits of infection prevention by observing staff during hand hygiene and wound care techniques. IP 1 stated she followed staff and asked questions. IP 1 stated if she saw incorrect techniques, she gave (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in-services. IP 1 stated she followed the Centers for Disease Control (CDC) guideline for EBP or contact precautions. IP 1 stated she assessed wounds and wounds that were chronic and draining she put on EBP. IP 1 stated she was familiar with Resident 38's wounds but was not sure why she was not placed on EBP. IP 1 stated she had seen Resident 38's wound vac and had observed dressing changes. IP 1 stated her expectation was for Resident 38's ileostomy site to be separately cleaned from the surgical sites. IP 1 stated hand hygiene should have been performed prior to donning new gloves and in-between each site change. IP 1 stated hand hygiene was important to prevent cross contamination from each site. IP 1 and IP 2 both stated EBP were put in place to protect residents as well as self from infection and to prevent cross-contamination. The facility's EBP policy and procedure (P&P) was reviewed with IP 1 and IP 2 and indicated EBP was to include wounds and surgical wounds. IP 1 and IP 2 stated Resident 38 should have been placed on EBP. During an interview on 7/17/26 at 2:28 p.m. with the Director of Nursing (DON) the DON stated her expectation during wound care was for staff to follow infection prevention guidelines preventing cross contamination, which included removing gloves between cleaning surgical sites, washing hands before and after wound care, and wearing appropriate PPE for EBP residents. The DON stated her expectation was for the IP nurses to identify EBP residents and educate staff. The DON stated Resident 38 should have been on EBP. The DON stated EBP was put in place to protect residents from infections and to keep everyone one safe. The DON stated she was ultimately responsible for making sure residents had safe appropriate care. During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated 9/27/24, the P&P indicated, .it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms [MDRO].refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition [e.g., residents with wounds or indwelling medical devices].staff receive training on high-risk activities and common organisms that require enhanced barrier precautions.clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment [PPE], and the high-contact resident care activities that require the use of gown and gloves.an order for enhanced barrier precautions will be obtained for residents with any of the following.wounds [e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers] and/or indwelling medical devices [e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes] even if the resident is not known to be infected or colonized with a MDRO.high-contact resident care activities include.dressing.bathing.transferring.providing hygiene.changing linens.changing briefs or assisting with toileting.device care or use.wound care: any skin opening requiring a dressing.enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals.During a review of the facility's P&P titled, Wound Care, dated 10/2010, the P&P indicated, .verify there is a physician's order for this procedure.personal protective equipment [e.g., gown, gloves, mask, etc., as needed].arrange the supplies so they can be easily reached.wash and dry your hands thoroughly.put on exam glove. Loosen tape and remove dressing.pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly.wear gloves when physically touching the wound or holding a moist surface over the wound.place one [1] gauze to cover all broken skin. Wash tissue around the wound that is usually covered by the dressing, tape or gauze with antiseptic or soap and water.remove dry gauze. Apply treatments as indicated.dress wound.wash and dry your hands thoroughly.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056266	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Keystone Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3672 North First Street Fresno, CA 93726	
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to provide a safe and comfortable working environment for kitchen staff when temperature readings exceeded 85 degrees Fahrenheit (F -measurement of temperature) in the kitchen.This failure resulted in kitchen staff visible sweating during plating of meals in the kitchen which could increase the risk of unsafe and unsanitary handling of resident food.Findings:During a concurrent observation and interview on 7/14/26 at 8:45 a.m. with the Certified Dietary Manager (CDM), in the kitchen, no thermometer or thermostat was observed in the kitchen. The CDM stated there was no thermometer or thermostat in the kitchen to monitor temperatures.During a concurrent observation and interview on 7/14/26 at 10:00 a.m. with the Maintenance Director (MND) and the CDM, in the kitchen, the MND took the temperature in the kitchen. No food preparation or food serving was observed. The temperature was 85 F near the dishwasher, 85.1 F near the tray line table, and 86 F near the dry food storage wall. Cooking spices were observed stored in the kitchen environment, outside of the dry food storage room.During a concurrent interview and record review on 7/15/26 at 10:34 a.m., the facility's policy and procedure (P&P) titled, Storage of Food and Supplies, dated 2023, was reviewed. The RD stated the P&P did not include kitchen temperature ranges. The RD stated the P&P indicated dry food needed to be stored between 50 F to 85 F. The RD stated if food was held or stored over 85 F it could spoil.During an observation on 7/15/26 at 11:47 a.m., in the kitchen during lunch tray line, [NAME] (CK) 1 was observed sweating during tray line, while plating resident food. During a concurrent observation and interview on 7/15/26 a.m. at 12:20 p.m. with the CDM, in the kitchen during lunch tray line, a wall thermometer was observed on the wall, near the kitchen entrance. The CDM stated he placed the wall thermometer yesterday. The wall thermometer was 90 F.During a concurrent observation and interview on 7/15/26 at 2:13 p.m. with the CDM and Registered Dietician (RD), the kitchen wall thermometer was 94 F. The RD stated it was warm in the kitchen.During a concurrent observation and interview on 7/15/26 at 2:16 p.m. with Dietary Aide (DA) 1, DA 1 was observed sweating. DA 1 stated the kitchen was hot and not comfortable to work in. DA 1 stated kitchen temperature increased during food preparation and tray line which caused kitchen staff to sweat while handling food.During a concurrent observation and interview on 7/15/26 at 2:19 p.m. with CK 2, CK 2 was observed sweating. CK 2 stated the kitchen was always hot, even when food was not being made or served. CK 2 stated the facility kitchen was not comfortable to work in when temperatures were hot.During a concurrent observation and interview on 7/15/26 at 2:23 p.m. with the RD, the RD stated the kitchen was warm. The RD stated she observed kitchen staff sweating. The RD stated if kitchen staff were sweating in the kitchen it was not a comfortable environment.During a concurrent observation and interview on 7/15/26 a.m. at 3:58 p.m. with the CDM, in the kitchen, the wall thermometer was 94 F.During a concurrent observation and interview on 7/16/26 a.m. at 1:34 p.m. with the CDM and the MND, in the kitchen, the MND took the temperature in the kitchen. No food preparation or food serving was observed. The temperature was 90 F near the dishwasher, 95.4 F near the 3-compartment sink, 89.4 F near the dry food storage wall, and 90 F near the handwashing sink. During an interview on 7/17/26 at 9:41 a.m. with the CDM, the CDM stated prior to 7/15/26 temperatures in the kitchen were not taken or recorded by anyone. The CDM stated the kitchen temperature would be unknown without a thermometer or monitoring.During an interview on 7/17/26 at 9:52 a.m. with the RD, the RD stated prior to 7/15/26 there was no wall thermometer in the kitchen to monitor kitchen temperatures and no staff had been assigned to monitor kitchen temperatures. The (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RD stated kitchen staff were at risk of sweating or heat illness in a hot environment. The RD stated sweating while handling food posed an infection control risk if sweat got on resident food or kitchen equipment which could contaminate food. During an interview on 7/17/26 at 2:11 p.m. with the Director of Nursing (DON), the DON stated she expected the facility to provide a safe, comfortable and sanitary kitchen environment for staff and residents, per facility policy and food safety standards of practice. The DON stated hot kitchen temperatures were not safe or comfortable for staff if they were sweating. The DON stated there was a risk sweat could contaminate resident food which posed an infection control risk to residents. The DON stated prior to 7/15/26 kitchen temperatures were not monitored. The DON stated facility policy and procedure were not being implemented when kitchen temperatures were not monitored. During a review of the facility's policy and procedure (P&P) titled, Indoor Heat Illness Prevention, dated 1/1/26, the P&P indicated, "[facility name] will protect employees working in indoor areas where temperatures may reach 85 F or higher. the Dietary Manager or designee will check and document temperatures in the kitchen when hot conditions are expected, during the hottest cooking period, and following prolonged delivery or open-door events. temperature records will include the date, time, location, reading, and corrective actions. During a review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated, "food and supplies will be stored properly and in a safe manner. recommended temperature is 50 [degrees] F- 85 [degrees] F - if dry food storage goes over 85 F take corrective action. During a review of the facility's P&P titled, Homelike Environment, dated 2/2021, the P&P did not include comfortable and safe kitchen temperature ranges. The P&P indicated the facility maintained a comfortable and safe temperature of 71 degrees F to 81 degrees F for residents. During a review of the professional weather service, National Weather Service, retrieved from https://www.weather.gov/, the recorded high temperature for Fresno, California was 104 degrees F on 7/14/26, 106 degrees F on 7/15/26, and 102 degrees F on 7/16/26. During a review of the 2022 Federal Food and Drug Administration (FDA) Food Code, Ventilation Section 6-304.11 Mechanical, indicated "If necessary to keep rooms free of excessive heat, steam, condensation, vapors, obnoxious odors, smoke, and fumes, mechanical ventilation of sufficient capacity shall be provided .		