STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056279	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra View Homes	1155 E. Springfield Avenue Reedley, CA 93654

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on interview, record review, and facility policy review, the facility failed to accurately code the Minimum Data Set (MDS) for 2 (Resident #19 and Resident #38) of 14 sampled residents. Findings included: A facility policy titled, Minimum Data Set, dated dated [DATE], revealed, To provide an accurate assessment of all residents through clinical competence, observational, interviewing, and critical thinking skills, combined together to develop individualized plan of care for each individual. 1. An Admission Record revealed the facility admitted Resident #19 on 03/17/2022. According to the Admission Record, the resident had a medical history that included a diagnosis of chronic obstructive pulmonary disease. A significant change in status MDS, with an Assessment Reference Date (ARD) of 04/02/2025, revealed Resident #19 was rarely/never understood. The MDS Coordinator was interviewed on 04/09/2025 at 1:25 PM. The MDS Coordinator stated that it was important for the MDS to be accurate because the MDS reflected the resident's condition. The MDS Coordinator reviewed the MDS for Resident #19 and stated she had made an error when she coded the resident was rarely/never understood. The MDS Coordinator reported on 04/09/2025 at 3:10 PM that she amended Resident #19's MDS to correct the resident's cognitive ability and that she had been unaware the MDS was inaccurate until the inaccuracy was brought to her attention. The Director of Nursing (DON) was interviewed on 04/09/2025 at 3:20 PM and stated she expected the MDS to be accurate. The DON stated if the resident's cognitive status was not correct, the MDS was inaccurate. The Executive Director (ED) was interviewed on 04/10/2025 at 9:05 AM. The ED stated there needed to be communication between the staff to ensure the MDS was accurate. 2. An Admission Record revealed the facility admitted Resident #38 on 09/22/2023. According to the Admission Record, the resident had a medical history that included an anxiety disorder and major depressive disorder. (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A quarterly MDS, with an Assessment Reference Date (ARD) of 02/16/2025, indicated Resident #38 had a Staff Assessment for Mental Status (SAMS) that revealed the resident had modified independence in cognitive skills for daily decision making. The MDS indicated the resident did not have an active diagnosis of anxiety disorder or depression. The MDS Coordinator was interviewed on 04/09/2025 at 1:01 PM. The MDS Coordinator stated she amended Resident #38's MDS to include their diagnoses of depression and anxiety. The Director of Nursing was interviewed on 04/09/2025 at 3:20 PM and stated she expected depression and anxiety to be included on the MDS for Resident #38 under the MDS section that included active diagnoses. The Executive Director (ED) was interviewed on 04/10/2025 at 8:57 AM. The ED stated she expected the MDS to be accurate and to include all diagnoses that were pertinent to Resident #38's care. She stated she expected Resident #38's depression and anxiety to be captured on the MDS.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 22445 Based on interview, record review, and facility policy review, the facility failed to refer a resident to the appropriate state-designated authority for a level II preadmission screening and resident review (PASRR) when 2 (Resident #19 and Resident #39) of 2 sampled residents reviewed for PASRR were diagnosed with a new serious mental illness. Findings included: A facility policy titled, PASRR Policy and Procedure, dated 04/04/2023, revealed, The PASRR consists of a Level I Screening, a Level 2 evaluation (if needed), and a determination, The PASRR is divided into two components, the Preadmission Screening (PAS) and the resident review (RR). The PAS process is completed by the hospital prior to an individual discharging to a skilled nursing facility (SNF). A SNF can also complete the PAS process, but only when the individual is being admitted directly from the community. The RR process is completed for current SNF residents, readmissions, or inter-facility transfers when there is a significant change in the individual's physical or mental condition. In the case of an RR, the NF [nursing facility] initiates the process by submitting a Level I Screening as an RR in the PASRR system. The policy specified, 3. The MDS coordinator shall complete the RR after 30 days from admission, and when there is a significant change in the resident's physical or mental condition. 1. An Admission Record revealed the facility admitted Resident #19 on 03/17/2022. According to the Admission Record, the resident received diagnoses of bipolar disorder and anxiety disorder on 03/12/2024. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/02/2025, revealed Resident #19 had active diagnoses to include anxiety disorder and bipolar disorder. Resident #19's Care Plan Report included a focus area revised 04/05/2025, that indicated the resident used anti-anxiety medication related to a diagnosis of anxiety disorder. Resident #19's medical record revealed no evidence to indicate the facility referred the resident to the appropriate state-designated authority for a level II PASRR evaluation when the resident received a new mental illness diagnosis. The Admissions Coordinator (AC) was interviewed on 04/09/2025 at 11:08 AM. The AC stated if a resident received a new mental illness diagnosis after admission, the MDS Coordinator was responsible for updated the PASRR. The AC stated that without the psychiatric diagnoses included, the state agency would not have requested a level II PASRR, but not having a level II PASRR had not affected Resident #19's care. The MDS Coordinator was interviewed on 04/09/2025 at 1:25 PM and stated she was unaware Resident #19 required a level II PASRR. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Executive Director was interviewed on 04/10/2025 at 9:05 AM and stated she expected staff to revise and resubmit the PASRR to the state agency. 2. An Admission Record revealed the facility admitted Resident #39 on 07/03/2023. According to the Admission Record, the resident received diagnoses of psychosis, anxiety disorder, and dementia with agitation on 11/08/2023. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/28/2024, revealed Resident #39 had active diagnoses to include non-Alzheimer's dementia, anxiety disorder, and psychotic disorder. Resident #39's Care Plan Report included a focus area revised 07/10/2024, that indicated the resident used anti-anxiety medications related to a diagnosis of anxiety disorder. Resident #39's medical record revealed no evidence to indicate the facility referred the resident to the appropriate state-designated authority for a level II PASRR evaluation when the resident received a new mental illness diagnosis. The MDS Coordinator was interviewed on 04/09/2025 at 1:25 PM and stated she was unaware Resident #39 required a level II PASRR. The Executive Director was interviewed on 04/10/2025 at 9:05 AM and stated she expected staff to revise and resubmit the PASRR to the state agency.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22445 Based on interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive care plan that addressed hospice care for 1 (Resident #38) of 1 sampled resident reviewed for hospice and end of life. Findings included: A facility policy titled, Comprehensive Individualized Resident Care Plan (Activities) Isolation, dated 01/01/2024, indicated Comprehensive Individualized resident care plans provide a past and current history to current issues, illnesses, medication use, and another other factors. An Admission Record revealed the facility admitted Resident #38 on 09/22/2023. According to the Admission Record, the resident had a medical history that included an anxiety disorder and major depressive disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2025, indicated Resident #38 had a Staff Assessment for Mental Status (SAMS) that revealed the resident had modified independence in cognitive skills for daily decision making. The MDS indicated that the resident received hospice care. Resident #38's Care Plan Report with an admitted [DATE], revealed no evidence to indicate a care plan that addressed hospice services. Resident #38's Order Summary Report with orders active as of 04/09/2025, revealed an order dated 09/22/2023, that directed admitted to hospice, no hospitalization , routine laboratory tests or x-rays without prior authorization. The MDS Coordinator was interviewed on 04/09/2025 at 1:01 PM. The MDS Coordinator stated she typically included hospice on a resident's care plan but did not add the residents' code status to the care plan since the code status was included in the physician's orders. The MDS Coordinator stated it was important to add hospice to the care plan so facility staff would be able to identify the reason the resident was admitted to hospice and to alert staff that another team would be working with a resident. The MDS Coordinator confirmed that Resident #38 received hospice services and that she did not include hospice services on Resident #38's care plan with information about what would be provided by the hospice agency. On 04/09/2025 at 3:10 PM, the MDS Coordinator stated she amended Resident #38's care plan to include hospice and the services provided. The MDS Coordinator stated she had been unaware she omitted hospice on the resident's care plan until the omission was brought to her attention. The Director of Nursing (DON) was interviewed on 04/09/2025 at 3:20 PM and stated it was important to include hospice on the resident's care plan so facility staff would know who provided what type of care. The DON stated she expected the care plan to include the reason the resident admitted to hospice and any specific requests Resident #38 and/or their family might have. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Executive Director was interviewed on 04/10/2025 at 8:57 AM and stated she expected hospice care to be identified on Resident #38's care plan.