| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056279 | A. Building<br>B. Wing | 02/11/2026 |

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

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.<br><br>Based on interview record review, the facility failed to have a qualified, full-time certified dietary manager (CDM) for oversight of the Food and Nutrition Services.This failure had the potential of compromising the safety and nutritional status of residents through potential transmission of foodborne illnesses (illness that comes from eating contaminated food) and decreased quality of food for 52 of 52 residents who received food from the kitchen and could negatively affect the resident's quality of life and health.Findings:During an interview on 2/5/26 at 3:40 p.m. with Dietary Supervisor (DS) 1, DS 1 stated the CDM was on leave until 4/25. DS 1 stated the Registered Dietician (RD) came to the facility for eight hours a week. DS 1 stated, We [ DS 1 and DS 2] are covering for her [CDM]. DS 1 stated DS 2 was going to school to obtain his CDM certification.During an observation and interview on 2/9/25 at 10:59 a.m. with DS 2, DS 2 stated he was covering the CDM position. DS 2 stated he was responsible for in-services for the kitchen staff. DS 2 stated he was responsible for making sure the dietary staff were trained and competent in performing their job. DS 2 stated residents could have gotten sick and could have gotten cross-contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and food borne illnesses without proper training. During a record review of the facility's CDM leave document untitled, dated 12/12/25, the document indicated the CDM should have returned from leave on 1/5/26.During a record review of the facility's CDM leave document untitled, dated 1/5/26, the document indicated the CDM should have returned from leave on 4/7/26.During a record review of the DS 2's Certification, undated, the Certification indicated DS 2 had one certificate for Food Protection Manager Certification. No CDM certificate was provided.During a record review of DS 1's Certification, undated, the Certification indicated DS 1 was certified for California food handler and food protection manager. No CDM certification was provided.During an interview on 2/9/25 at 3:17 p.m. with the RD, the RD stated she came in one time a week on average for eight hours. The RD stated she was available on the phone. The RD stated DS 2 was covering for the CDM. The RD stated she spoke with DS 2 about residents' therapeutic diet (a specialized, medically prescribed meal plan that modifies a regular diet by adjusting nutrients, calories, or texture to treat or manage specific diseases, conditions, or intolerances) and looked at his quarterly (three months) notes. The RD stated DS 2 was providing the kitchen staff in-services. The RD stated it was important that the CDM had adequate training and certification to ensure ongoing training was done to prevent potential for cross-contamination and foodborne illness.During an interview on 2/11/26 at 12:15 p.m. with the Administrator (ADM), the ADM stated the facility had a full-time CDM and the CDM was out on leave since 12/25. The CDM stated DS 2 was filling the CDM role until the CDM return date of 4/26. The ADM stated the RD was in the facility for eight hours a week and available on call when needed. The ADM stated the RD was supposed to supervise the kitchen staff. The ADM stated DS 2 was getting his education and would be done with school by 4/26. The ADM stated DS 2 could have contacted the RD when needed. The ADM stated it was important to have a CDM on site to ensure things were checked, accomplished and followed through. The ADM stated residents could have gotten sick when there was no one supervising the kitchen staff.During a review of the facility's job description titled<br>(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 |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| F 0801<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Food & Nutritional Manager, undated, the job description indicated, Maintain employee competency of all kitchen staff .Qualifications: 1. Be a certified dietary Manager having met eligibility requirements for food, and passed a nationally recognized credentialing examination, Maintain a current Certified Dietary Manager Certificate. During a review of the California Code, Health and Safety Code - HSC S 1265.4, the HSC indicated, A licensed health facility, shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b). to supervise dietetic service operations. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>Based on observation, interviews, and record review the facility failed to ensure Dietary Aide (DA) 1, DA 2 and Maintenance (MAINT) 1 were trained to carry out the functions of the food and nutrition services safely and effectively for 52 of 52 residents when:1.DA 1 did not demonstrate and DA 2 did not verbalize the proper use of a test strip (paper that measures the concentration of quaternary ammonium compounds [chemicals that kills germs on surfaces] for the sanitizing bucket (a container used to store and mix a chemical solution that reduces germs on surfaces).This failure had the potential for improper disinfection of surfaces increasing the risk of cross-contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure of foodborne illnesses (a condition where a person becomes sick after consuming contaminated food or beverages. It is caused by the ingestion of harmful microorganisms, such as bacteria, viruses, parasites, or toxins), to all residents.2. MAINT 1 did not verbalize the proper cleaning procedure for the ice machine according to the manufacturer's guideline.This failure had the potential for cross- contaminated ice to be served to residents, thereby increasing the risk of foodborne illness and hospitalization of all the residents in the facility.Findings:1. During a concurrent observation and interview on 2/5/26 at 9:37 a.m. in the kitchen, DA 1 placed a test strip into a red sanitizing bucket. DA1 took out the test strip and compared the color of the strip to the bottle and DA 1 stated it was at 200 parts per million (ppm - a unit of measurement used to describe the concentration of a substance in a mixture). DA 1 stated 200 ppm was good. DA 1 stated she was responsible for preparing the sanitizing bucket. DA 1 stated, I put the test strip in the red bucket until it changes color. DA 1 stated, I put the test strip in the bucket for 1-2 seconds. DA 1 stated she had an in-service last week on sanitizing. DA 1 stated it was important to properly test the sanitizing solution to ensure the solution was within range. DA 1 stated the solution in the bucket was used to clean the germs on the kitchen surface. DA 1 stated residents could have gotten sick from cross-contamination and infections.During an interview on 2/9/26 at 10:14 a.m. with DA 2, DA 2 stated he was responsible for testing the sanitizing solution. DA 2 stated he rinsed the sanitizing bucket, obtained the sanitation solution from the dispensary and checked the solution with the test strip. DA 2 stated, I usually put in the strip, and it turns out right away. DA 2 stated the strip will turn to a different color instantly and he would have compared it to the bottle. DA 2 stated the ranges for the test should have been at 200 ppm. DA 2 stated inaccurate testing of the sanitizing solution could cause pathogens to grow. DA 2 stated not having the sanitizing solution in the appropriate ranges could have caused cross-contamination when surfaces were not cleaned properly. DA 2 stated, We touched base on it last week. DA 2 stated residents could have been hospitalized and died from food borne illness and cross-contamination.During an observation and interview on 2/9/25 at 10:59 a.m. with Dietary Supervisor (DS) 2, DS 2 stated he was unsure how long the strip should be in the sanitizing solution. DS 2 went to look at the policy and procedure binder. DS 2 stated DA 1 and DA 2 should have left the test strip in the solution for 10 seconds to ensure the strip was in the solution for accurate reading. DS 2 stated DA 1 and DA 2 were not competent in their training and needed more training. DS 2 stated he was responsible for making sure the dietary staff were trained and competent in performing their jobs. DS 2 stated residents could have gotten sick and could have gotten cross-contamination and food borne illness from not having kitchen surface cleaned and sanitized.During an interview on 2/9/26 at 4:15 p.m. with the Registered Dietician (RD), the RD stated DA 1 and DA 2 should have followed the instructions per manufacture or policy guidelines. The RD stated DA 1 and DA 2 were not competent in the sanitization process when they were not able to demonstrate and verbalize the correct timing. The RD stated DA 1 and DA 2 should have proper training so the facility policy could be followed. The RD stated when DA 1 and DA 2 did not test the sanitizing solution correctly, this could have caused items to not be sanitized and put residents at<br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | risk for cross-contamination from food borne illnesses. The RD stated residents could have nausea, vomiting, diarrhea and other stomach issues and could have required hospitalization. The RD stated the certified dietary supervisor, and dietary supervisor were responsible for staff training. The RD stated the certified dietary supervisor ? was responsible for ensuring the policy was being followed.During a review of the manufacture's instructions titled, [Manufacture's name] QT-40 Instructions, undated, the Manufacture's Instruction indicated, Dip paper in quat solution. for 10 seconds.During a review of the facility's policy and procedure (P&P) titled, Sanitizing equipment and surfaces with Quaternary Ammonium (QUAT) Sanitizer, dated 2023, the P&P indicated, Test the sanitizer solution by placing a sanitizing test strip in the solution. Allow the test strips to sit in the solution for 10 seconds.2 . During an observation and interview on 2/5/26 at 10:10 a.m. with the Maintenance Supervisor/Operational Manager (MNT), the ice machine had black and pink substance found inside and a white substance was found outside. The MNT stated the ice machine should not have black and pink substances inside and white substances outside. The MNT stated it was unacceptable to have black and pink substances inside the ice machine and dust outside on the ice. The MNT stated MAINT 1 was responsible for cleaning the ice machine monthly. During an interview on 2/5/26 at 10:26 a.m. with MAINT 1, MAINT 1 stated, I cleaned the ice machine monthly or every three weeks. MAINT 1 stated, I get the descaler [a cleaning solution used to removed lime scale and mineral deposit] chemical and put 1 tablespoon into the tray [area where cleaning solution goes for cleaning] and let it run through the cycle. MAINT 1 stated he took ice machine components apart and sprayed the front and the probe with a descaling solution mixed with two bottle caps [cap from the bottle of the descaling solution] of descaler mixed with 10 ounces (unit of measurement) of hot water. MAINT 1 stated he soaked the ice machine components for one minute and washed it off using a solution made with two caps full of sanitizing solution mixed with water. MAINT 1 stated he mixed two bottle caps of sanitizing solution with eight ounces of hot water and used the solution to clean the inside and outside of the ice machine. MAINT stated he was trained to clean the ice machine by an employee who was no longer working at the facility.During an interview on 2/9/26 at 4:23 p.m. with the RD, the RD stated, The person who is servicing [ice-machine] should be competent in knowing what they are doing. The RD state, The ice machine should be cleaned according to the manufacturer's guideline, The RD stated the ice machine should have been cleaned properly to prevent cross-contamination. The RD stated not cleaning the ice machine by manufacturer's guidelines could have caused pathogens (mold, virus and bacteria) to grow. The RD stated, It is important to make sure they are removing pathogen and bacterial from the ice. The RD stated, Resident could have gotten foodborne illness and gotten nausea, vomiting, diarrhea and other gastrointestinal (GI) issues and could have cause hospitalization. The RD stated she was not sure who trained and supervised MAINT 1.During an interview on 2/10/26 at 11:40 a.m. with the MNT, the MNT stated MAINT 1 was trained by an employee that was no longer with the facility. The MNT stated MAINT 1 should have followed the manufacturer's guidelines for cleaning the ice machine. The MNT stated MAINT 1 was not competent and needed to be retrained. The MNT stated MAINT 1 was responsible for cleaning the ice machine. The MNT stated not cleaning the ice machine according to the manufacturer's guidelines could have caused cross-contamination to the ice. The MNT stated everyone who consumed ice from the ice machine could have gotten foodborne illness. The MS stated cross-contaminated ice could have put everyone at risk for being hospitalized . The MNT stated it was not acceptable for the ice machine to have black particles, pink substance inside the ice machine and it should have been cleaned thoroughly. During an interview and record review on 2/11/26 at 12:36 p.m. with the Administrator (ADM) the ADM was shown photos of the black and pink substance inside the ice-machine. The ADM stated maintenance staff should have cleaned and sanitized the ice-machine. The ADM stated the ice machine should be cleaned and sanitized to prevent ice from being cross-contaminated. The ADM stated there could have been potential chance of sickness from cross-contamination and hospitalization from the ice-machine. The ADM stated MAINT 1 needed more<br>(continued on next page) |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | training on cleaning the ice-machine and following the manufacturer's guidelines.During a review of the facility's In-Service titled, The Importance on Maintaining the Ice Machine, dated 7/31/25, the in-service indicated, It's important we follow the guideline of the manufacture step by step on sanitizing and cleaning. During a review of the facility's manufacturer's operation instruction titled, No title undated, the manufacturer's operation instruction indicated, .mix a solution of cleaner warm luke warm water depending upon the amount of mineral buildup.use ratio in the table below to mix enough solution to thoroughly clean all parts.cleaner.1 [gallon-units of measurement] 16 ounces (oz-unit of measurement) cleaner.use 1/2 of the cleaner/water mixture to clean all components.soak part for 5 minutes (15-20 minutes for heavily scaled parts). While components are soaking, use half descaler and water solution to clean all food zone surfaces of the ice machine and bin.Mix a solution of sanitizer with warm water. Solution type: sanitizer. Water: 3 gal (gallon-unit of measurement) Mixed with: 2 oz (60 ml (milliliter- a unit used to measure capacity) . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices were followed for 52 of 52 residents when:1. Two bags of cabbage with a used by dated 2/2/26, a bag of celery with a used by date of 1/30/26 and a bag of daikon with a used by date of 2/2/26 were stored on the shelves next to other produce in the walk-in refrigerator.2. Two cartons of apple cobbler with a received date of 7/22/25 with no used by date were on the top self in a freezer.3. Two packs of unlabeled cooked chicken with no pulled-out date and used by date were on a tray next to the deli ham in refrigerator 3.4. Black and pink substances inside and white substances were found outside the ice machine.5. One staff member stored their lunch bag inside the resident refrigerator.These failures had the potential risk of cross contamination (process by which bacteria is transferred from one object or substance to another, with harmful effect) and exposure of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) from improperly stored and labeled food and could cause foodborne illness ( illness that comes from eating contaminated food) to 55 of 55 residents.6. The Resident's food refrigerator at the west wing nursing station was not within the recommended temperature.This failure placed residents at risk of consuming food which was not within the recommended temperatures which could lead to gastrointestinal illness (illness that affects the digestive system [GI tact] which runs from mouth to anus) and serious health conditions. Findings:<br><br>1. During a concurrent observation and interview on 2/4/26 at 1:46 p.m. with Dietary Supervisor (DS) 1, in the walk in produce refrigerator Two bags of cabbage with a used by dated 2/2/26, a bag of celery with a used by date of 1/30/26 and a bag of daikon with a used by date of 2/2/26 were stored on the shelves next to other produce in the walk-in refrigerator. DS 1 stated the items should have been tossed by the used by dates.<br><br>During an interview on 2/9/26 at10:14 a.m. with Dietary Aide (DA) 2, DA 2 stated, I take care of stocking and delivery. DA 2 stated It is everyone's job to look through the refrigerator and freezer to check expired items. DA 2 stated expired items were no longer edible and were a safety hazard. DA 2 stated items past the used by dates could have caused residents to have foodborne illness. DA 2 stated storing items past the used by date could have caused cross-contamination with other products.<br><br>During an interview on 2/9/26 at10:28 a.m. with DS 2, DS 2 stated the two bags of cabbage, a bag of celery and daikon should have been caught and discarded on their used by date. DS 2 stated the kitchen staff were responsible for ensuring it was thrown away at the time of their used by date. DS 2 stated the items could have been served to residents. DS 2 stated residents could have gotten foodborne illness. DS 2 stated residents could have gotten sick and hospitalized when consuming items past their used by date.<br><br>During an interview on 2/9/26 at 3:27 p.m. with the Registered Dietician (RD), the RD stated the items should have been discarded by the used by date. The RD stated residents could have gotten foodborne illness from consuming food past their used by date. The RD stated used by items could have caused cross-contamination when stored with other items. The RD stated residents could have nausea, vomiting and diarrhea which could have led to hospitalization. The RD stated all kitchen staff were responsible for ensuring everything was discarded by the used by date. The RD stated the kitchen staff should have been checking it daily. The RD stated she and DS 2 were responsible for<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | checking on the kitchen staff.<br><br>During a review of the facility's policy and procedure (P&P) titled, Storage, rotation and discard of food and beverage items from dietary department to skilled nursing unit, dated 8/10/16, the P&P indicated, All food and beverage brought into the facility for resident consumption be labeled and dated for monitoring of food safety.Food or beverages past the manufacture expiration date will be discard immediately by designated facility staff.<br><br>2. During a concurrent observation and interview on 2/4/26 at 2:05 p.m. with DS 1, two cartons of apple cobbler pie with a received dated 7/22/25 with no used by date were on the top self in freezer 4. DS 1 stated the apple cobbler pies was past the expiration date and should have been thrown away.<br><br>During an interview on 2/9/26 at 10:41 a.m. with DS 2, DS 2 stated Our staff should have caught it [items past their used by date]. DS 2 stated DA 2 should have gone through the freezer during inventory and tossed it. DS 2 stated residents could have gotten sick from foodborne illness when they consumed food past the used by date. DS 2 stated residents could have diarrhea, vomiting and other issues which could have led to hospitalization after consuming food past the used by date.<br><br>During an interview on 2/9/26 at 3:53 p.m. with the RD, the RD stated items should have been tossed by the used by date. The RD stated residents who consumed items past the used by date had the potential for foodborne illness. The RD stated residents with foodborne illness could have been hospitalized . The RD stated residents could have diarrhea, nausea and vomiting and other stomach issues from consuming food past the used by date. The RD stated the certified dietary manager, DS 1 and DS 2 should have been responsible for ensuring all kitchen staff were responsible in discarding items past the used by date and it should have been done daily.<br><br>During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection control, dated 2023, the P&P indicated, 10. Refer to the suggested Freezer Storage guidelines for recommended storage time of food items.Baked Goods.Fruit pies, baked or unbaked.3 months.<br><br>3. During a concurrent observation and interview on 2/4/26 at 2:20 p.m. with DS 1, in refrigerator 3, two packs of unlabeled cooked chicken with no pulled-out date and used by date were on a tray next to the deli ham. DS 1 stated the bags were cooked chicken meat and should have been labeled with a pulled-out date and a used by date.<br><br>During an interview on 2/9/26 at 10:54 a.m. with DS 2, DS 2 stated the two packs of cooked chicken should have been labeled with a pulled-out date and used by date. DS 2 stated it was important to ensure things were labeled for timeline and food safety. DS 2 stated resident could have gotten diarrhea, nausea and vomiting from consuming food past the used by date. DS 2 stated resident could have foodborne illness. DS 2 stated residents could have been hospitalized from foodborne illness.<br><br>During an interview on 2/9/25 at 3:59 with the RD, the RD stated the cook chicken should have been labeled with a pulled-out date and used by date. The RD stated residents could have food born illness from consuming items past the used by date. The RD stated it was important for items to be labeled to ensure it was safe to consume. The RD stated there was potential for items to be served past the used by date. The RD stated residents could have diarrhea, vomiting and diarrhea from consuming food. The RD stated the facility did not follow their policy and procedure.<br><br>During a review of the facility's P&P titled, Sanitation and Infection Control, dated 2023, the P&P<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | indicated, 11.All meat.placed in the refrigerator for thawing must be labeled.with pull by date and used by date.<br><br>4. During an observation and interview on 2/5/26 at 10:10 a.m. with the Maintenance Supervisor/Operational Manager (MNT), the ice machine had black and pink substances inside and white substances was found outside. The MNT stated the ice machine should not have black and pink substances inside and white substances outside. The MNT stated it was unacceptable to have black and pink substances inside the ice and white substances outside the ice. The MNT stated MAINT 1 was responsible for cleaning the ice machine monthly.<br><br>During an interview on 2/9/26 at 4:23 p.m. with the RD, the RD stated the ice machine should have been cleaned properly to prevent cross-contamination. The RD stated not cleaning the ice machine could have caused pathogens (mold, virus and bacteria) to grow. The RD stated, It is important to make sure they are removing pathogen and bacterial from the ice. The RD stated, Resident could have gotten foodborne illness and gotten nausea, vomiting, diarrhea and other gastrointestinal (GI-conditions affecting the digestive tract, including the stomach, intestines, liver, and gallbladder, ranging from mild discomfort to chronic diseases) issues and could have cause hospitalization.<br><br>During an interview on 2/10/26 at 11:40 a.m. with the MNT, the MNT stated MAINT 1 should have followed the manufacturer's guidelines for cleaning the ice machine. The MNT stated MAINT 1 was responsible for cleaning the ice machine. The MNT stated not cleaning the ice machine could have caused cross-contamination of ice. The MNT stated everyone who consumed ice from the ice machine could have gotten foodborne illness. The MNT stated cross-contaminated ice could have put everyone at risk for being hospitalized . The MNT stated it was not acceptable for the ice machine to have black particles and pink substances inside the ice machine and it should have been cleaned thoroughly.<br><br>During an interview and record review on 2/11/26 at 12:36 p.m. with the Administrator (ADM), the ADM was shown photos of the black and pink substance inside the ice-machine. The ADM stated the maintenance staff should have cleaned and sanitized the ice-machine. The ADM stated the ice machine should be cleaned and sanitized to prevent ice from being cross-contaminated. The ADM stated there could have been potential chance of sickness from cross-contamination and hospitalization of residents from consuming ice from the ice-machine.<br><br>During a review of the facility's P&P titled, The importance on Maintaining a Ice Machine, dated, the P&P indicated, Maintaining commercial ice machines in California is crucial for compliance with strict state health codes.to prevent bacterial/mold, growth.California health and Safety Codes regulate ice as foodborne illness.<br><br>5. During a concurrent observation and interview on 2/5/26 at 2:25 p.m. in the east dining room with DS 2, one staff member's lunch was stored in the resident refrigerator. DS 2 stated staff member's lunch should not be stored in the residents' refrigerator, and it could have caused cross-contamination into the residents' food. DS 2 stated residents' food could be cross-contaminated when it was stored with food items that came from unknown places. DS 2 stated residents could have gotten foodborne illness if they consumed cross-contaminated food. DS 2 stated residents could have eaten food that was not ordered for their therapeutic diet (specialized, medically prescribed meal plan that modifies a regular diet by adjusting nutrients, calories, or texture to treat or manage specific diseases, conditions, or intolerances) causing harm such as choking or other health related issues. DS 2 stated dietary staff were responsible for ensuring the residents' refrigerator was cleaned.<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview on 2/5/26 at 2:31 p.m. with Certified Nurse Assistant (CNA) 6, CNA 6 stated, It was my lunch bag. It was in the east dining room refrigerator. CNA 6 stated her lunch bag should have been in the break room. CNA 6 stated, I was working alone and I put it in there and I should have not put it in there. CNA 6 stated, The refrigerator is strictly for resident, and the residents could have gotten a hold of it. CNA 6 stated residents could have gotten harmed when consuming food from the lunch bag. CNA 6 stated residents could have choked on the food and the items in the lunch bag and the food could have been against their diet. CNA 6 stated she was trained to not put her lunch in the resident refrigerator last year.<br><br>During an interview on 2/9/26 at 4:20 p.m. with the RD, the RD stated it was not okay to store employee lunch in the resident refrigerator. The RD stated it could have caused cross-contamination and was not sanitary. The RD stated residents could have foodborne illness and infections. The RD stated residents could have choking hazards, foodborne illness and food allergies to the items in the lunch bag. The RD stated residents were at risk for GI upset, vomiting, diarrhea, hospitalization, and death.<br><br>During an interview on 2/11/26 at 12:45 p.m. with the ADM, the ADM stated staff should not be storing food in the resident refrigerator The ADM stated there could be cross-contamination from the employee lunch bag. The ADM stated staff did not follow our policy and procedure.<br><br>During a review of the facility's policy and procedures (P&P) titled, Resident Refrigerator and Outside food Storage, updated 2/11/26, the P&P indicated, It is the policy of the facility to maintain resident refrigerators in a manner that ensures food safety, infection control, and regulatory compliance. To reduce the risk of foodborne illness, only approved food items from authorized sources may be stored in resident refrigerators.Staff are strictly prohibited from storing personal food or beverages in resident refrigerators.<br><br>6. During a concurrent observation, interview, and record review on 2/6/26 at 11:03 a.m. in the west wing nursing station, with Licensed Vocational Nurse (LVN) 4, a black refrigerator had food stored in it and the refrigerator temperature was 32 degrees Fahrenheit ( degrees F- a scale for measuring temperature). There was a temperature guide displayed on the side of the refrigerator. The temperature guide was reviewed with LVN 4. The temperature guide indicated . At 32 degrees F and below, the food in your refrigerator will start to freeze. Keep your refrigerator temperature above 32 degrees F to avoid this, and if you want anything frozen, put it in the freezer which should be kept below 0 degrees F.<br><br>During a concurrent interview and record review on 2/6/26 at 11:10 a.m. with LVN 4, the facility's Temperature Log, dated November 2025, December 2025, January 2026 was reviewed. The temperature log indicated in the month of January 2026, the log was not completed 14 out of 31 times on the morning (AM) shift and the temperature was at 32 degrees F and below 11 times out of 17 recorded entries on the AM shift, the log was not completed 9 out of 31 times on the afternoon (PM) shift and the temperature was at 32 degrees F and below 10 times out of 22 recorded entry on the PM shift, and the log was not completed 1 out of 31 times on the night (NOC) shift and the temperature was at 32 degrees F and below 26 times out of 30 recorded entries on the NOC shift. The temperature log indicated in the month of December 2025, the log was not completed 7 out of 31 times on the AM shift and the temperature was at 32 degrees F and below 18 times out of 24 recorded entries on the AM shift, the log was not completed 5 out of 31 times on the PM shift and the temperature was at 32 degrees F and below 19 time out of 26 recorded entries on the PM shift, and the log was not completed 2 out of 31 times on the NOC shift and the temperature was at 32 degrees F and below 26<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | times out of 29 recorded entries on the NOC shift. The temperature log indicated in the month of November 2025, the log was not completed 7 out of 31 times on the AM shift and the temperature was at 32 degrees F and below 17 times out of 24 recorded entries on the AM shift, the log was not completed 1 out of 30 times on the PM shift and the temperature was at 32 degrees F and below 18 time out of 29 recorded entries on the PM shift, and the log was completed on the NOC shift and the temperature was at 32 degrees F and below 22 times out of 30 recorded entries on the NOC shift. LVN 4 stated the refrigerator was used to store residents' food and snacks. LVN 4 stated temperatures should be checked every day. LVN 4 stated checking the refrigerator was important to ensure the temperature of the refrigerator was in the ideal range. LVN 4 stated not checking the refrigerator temperature could lead to the refrigerator getting too hot or too cold and that could lead to spoiling of food. LVN 4 stated if food was not stored properly, residents could get sick. LVN 4 stated the temperature logs should have been completed.<br><br>During an observation on 2/9/26 at 4:18 p.m. at the west wing nursing station refrigerator, the refrigerator temperature was 24 degrees F.<br><br>During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), the pictures of the thermometer (an instrument used to measure how hot or cold something is[temperature]) in the west wing nursing station refrigerator and the temperature logs for the refrigerator, undated were reviewed. The DSD stated and validated the temperature of the refrigerator was 24 degrees F which indicated freezing zone. The DSD stated the food should be discarded. The DSD stated the refrigerator should be adjusted and corrected. The DSD stated this was important because it could cause damage to the residents and there could be adverse outcomes. The DSD stated the refrigerator log blanks should have been filled in. The DSD stated this was important because food could be harmful if not stored at the right temperature.<br><br>During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), the pictures of the thermometer in the west wing nursing station refrigerator and the temperature logs for the refrigerator, undated were reviewed. The DON stated the refrigerator food guide indicated food was freezing at 24 degrees F. The DON stated the expectation from the facility staff was that the refrigerator should have been at the appropriate temperature of 35 degrees F- 40 degrees F. The DON stated this was important to make sure there was no bacteria or frozen foods. The DON stated the failure could result in food spoilage, bacterial growth or compromised food safety. The DON stated the log was incomplete. The DON stated the facility policy states the night shift should monitor the temperatures. The DON stated it was important to maintain proper temperature of the refrigerators, otherwise there could be spoiled items or frozen items.<br><br>During a review of facility's document titled, The right temperature for your refrigerator and freezer, dated 6/26/25, the document indicated, Refrigerator temperature guide- Above 40 degrees - Any temperature above 40 degrees F may allow bacteria to multiply rapidly. At 40 degrees , the U.S. Food and Drug Administration says the recommended temperature is below 40 degrees F. Between 35 degrees and 38 degrees - the ideal refrigerator temperature is between 35 degrees F and 38 degrees F, below the safety threshold outlined by the FDA and above freezing. It's not uncommon for refrigerators to be a few degrees off the mark you set, so err on the side of too cold to avoid food spoiling more quickly or potential food safety issues. At 32 degrees - At 32 degrees F and below, the food in your refrigerator will start to freeze. Keep your refrigerator temperature above 32 degrees F to avoid this, and if you want anything frozen, put it in the freezer which should be kept below 0 degrees F.<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During a review of the facility's P&P titled, Refrigerator temperatures, dated 9/29/2009, the P&P indicated, . Purpose: to ensure that the temperatures of the refrigerator in the skilled nursing department are maintained between 36- 41 degrees at all times. Policy: the night shift chart nurse will check and document the temperature of the refrigerator located in the medication room and at the nurses station on a nightly basis to ensure temperatures are between 36-41 degrees at all times. If there is a malfunction and the temperature rises above 41 degrees for more than 1/2 hour, medications will be assessed and destroyed and replaced as needed. |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' water pitcher was within reach for five of eight sampled residents (Resident 9, 11, 13, 39 and 55), when the water pitcher was observed to be placed on the residents' dressers and were not accessible to the residents.This failure had the potential to violate Residents 9, 11, 13, 39, and 55's right to respect and dignity by neglecting their basic need for hydration, and undermining their autonomy and their right to person centered dignified care.Findings:During a concurrent observation and interview on 2/4/2026 at 3:35 p.m. in Resident 9's room, Resident 9 was observed dressed and lying in bed with his eyes closed. Resident 9's water pitcher was observed to be on his dresser and was not within Resident 9's reach.During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 9 was admitted to the facility from an assisted living /board and care/group home on [DATE] with diagnoses which include . Acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), epileptic seizures (a sudden, temporary surge of uncontrolled electrical activity in the brain that disrupts normal function), bipolar disorder (chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from high-energy manic episodes to low-energy depressive episodes), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) .During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/8/26, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 03 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS score indicated Resident 9 had severe cognitive impairment.During an observation on 2/4/2026 at 3:35 p.m. in Resident 11's room, Resident 11 was observed dressed, lying in bed, and unable to respond appropriately to questions asked. Resident 11's water pitcher was observed to be placed on his dresser and was not within Resident 11's reach.During a review of Resident 11's AR, dated 2/11/26, the AR indicated Resident 11 was admitted to the facility from an acute care hospital on 6/22/25 with diagnoses which include . essential hypertension (high blood pressure that has no single, identifiable medical cause), gastroesophageal reflux disease (condition where stomach acid frequently flows back into the tube connecting the mouth and stomach [esophagus]), varicose veins (swollen, twisted, and enlarged veins that usually appear blue or dark purple just under the skin's surface, most commonly in the legs) of unspecified lower extremity with ulcer of unspecified sites, alcoholic cirrhosis of liver with ascites (a severe, advanced stage of liver disease caused by long-term alcohol abuse), venous insufficiency (condition where leg vein valves are damaged or weakened, preventing blood from flowing efficiently back to the heart), anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life) .During a review of Resident 11's MDS, dated [DATE], the MDS section C indicated Resident 11 had a BIMS score of 07, which indicated Resident 11 had severe cognitive impairment.During an observation on 2/4/2026 at 2:38 p.m., Resident 13 was sitting in her wheelchair in her room. Resident 13's water pitcher was observed to be placed on her dresser and was not within Resident 13's reach.During a review of Resident 13's AR, dated 2/11/26, the AR<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | indicated Resident 13 was admitted to the facility from an acute care hospital on 2/28/25 with diagnoses which include . pneumonia (an infection that inflames the air sacs [alveoli] in one or both lungs, causing them to fill with fluid or pus), anemia (blood condition characterized by a shortage of healthy red blood cells, which reduces the blood's ability to carry oxygen to organs and tissues), Alzheimer's disease (a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple daily tasks), hyperlipidemia, heart failure (condition where the heart muscle is too weak or stiff to pump blood efficiently, failing to meet the body's oxygen needs), essential hypertension, Presence of cardiac pacemaker (a small, battery-operated, implantable device that acts as a backup to the heart's natural electrical system), depression (a serious, common medical illness characterized by persistent, intense feelings of sadness, low mood, or loss of interest in activities), hypokalemia (abnormally low levels of potassium in the blood, that affects the function of nerves and muscles, particularly the heart) .During a review of Resident 13's MDS, dated [DATE], the MDS section C indicated Resident 13 had a BIMS score of 06, which indicated Resident 13 had severe cognitive impairment.During an observation on 2/4/2026 at 2:31 p.m., Resident 39 was not in her room, Resident 39's water pitcher was observed to be placed on her dresser and was not within Resident 39's reach.During a review of Resident 39's AR, dated 2/11/26, the AR indicated Resident 39 was admitted to the facility from an acute care hospital on 8/28/25 with diagnoses which include . Hyperlipidemia (abnormally high levels of fats [lipids] in the blood), essential hypertension, neuromuscular scoliosis (a sideway curvature of the spine caused by underlying nerve or muscle disorders), multiple sclerosis (a chronic disease where the immune system mistakenly attacks the protective coating [myelin] surrounding nerve fibers in the brain and spinal cord), edema (swelling caused by an abnormal buildup of excess fluid trapped in the body's tissues) .During a review of Resident 39's MDS, dated [DATE], the MDS section C indicated Resident 39 had a BIMS score of 09, which indicated Resident 39 was moderately impaired.During an observation on 2/4/2026 at 3:35 p.m. in Resident 55's room, Resident 55 was observed dressed and sitting in bed. Resident 55's water pitcher was observed to be placed on his dresser and was not within Resident 55's reach.During a review of Resident 55's AR, dated 2/11/26, the AR indicated Resident 55 was admitted to the facility from an acute care hospital on 4/18/25 with diagnoses which include .type 2 diabetes mellitus (when the blood sugar levels in the body are too high), major depressive disorder (a serious, common medical illness characterized by persistent, intense feelings of sadness, low mood, or loss of interest in activities), anxiety disorder, essential hypertension, acute respiratory failure with hypoxia .During a review of Resident 55's MDS, dated [DATE], the MDS section C indicated Resident 55 had a BIMS score of 00, which indicated Resident 55 had severe cognitive impairment.During a concurrent observation and interview on 2/4/26 at 3:38 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 9, Resident 11 and Resident 55's room, the water pitchers were noted to be on the residents' dressers. CNA 4 stated the water pitchers should not have been placed on the residents' dressers. CNA 4 stated the water pitchers should be placed on the bedside table or nightstand, within the residents' reach so that the residents could access them easily without having to get up. CNA 4 stated the potential outcome of the water pitchers being placed out of reach included the risk of the residents attempting to get up unassisted and falling.During a concurrent observation and interview on 2/4/26 at 3:57 p.m. with Registered Nurse (RN) 1 in Resident 9, Resident 11 and Resident 55's room, the water pitchers were noted to be on the residents' dressers. RN 1 stated it was the responsibility of the CNA to place water pitchers in the residents' rooms. RN 1 stated as long as the water pitcher was near the residents' bedside it was acceptable. RN 1 stated residents on the [NAME] wing of the facility consisted of a combination of hospice (compassionate care for individuals with a terminal illness (typically less than six months to live) that focuses on comfort, dignity, and quality of life rather than curing the disease ), long term care and rehabilitation residents. RN 1 stated rehabilitation residents are short stay residents recovering from physical injuries such as broken or fractured legs with the goal of being discharged to their homes. RN (continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 1 stated long term care residents were more stable individuals who resided at the facility due to their families being unable to care for them and who presented with multiple comorbidities such as Alzheimer's disease, hypertension, and diabetes that were progressively worsening, leaving them unable to perform some of their activities of daily living (ADL- fundamental, routine self-care tasks essential for independent living, health, and safety, typically including bathing, dressing, eating, transferring (mobility), toileting, and continence ) independently. RN 1 stated as long as the water pitcher was in the room and on the residents' bedside it was acceptable. RN 1 stated he would not want the water pitcher to be placed somewhere that was not within the residents' reach.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), pictures of water pitchers placed on residents' dressers were reviewed. The DSD stated water pitchers should not have been placed on the dressers and should instead be placed on the bedside table where they were accessible to the residents. The DSD stated this was important in order to encourage adequate hydration. The DSD stated the potential outcome of the water pitcher being out of the residents' reach included the risk of dehydration.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), pictures of water pitchers placed on residents' dressers were reviewed. The DON stated the water pitchers should not have been placed on the residents' dressers and should instead be on the bedside table where residents could reach them. The DON stated the residents required a greater level of assistance. The DON stated and acknowledged that the facility staff could do better in ensuring residents' needs were met. The DON stated this was important so residents were able to access their water independently and remain adequately hydrated. The DON stated the potential outcome of the water pitchers being out of the residents' reach included the risk of dehydration and illness.During a review of the facility's document titled, Job Description, Certified Nurse Assistant (CNA), dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A certified nurse assistant is responsible for the direct care of the group of residents assigned, and provides the activities of daily living care, including ADL documentation, and psychosocial services (support actions that address the mental, emotional, social, and spiritual needs of individuals, particularly when facing illness, crisis, or disability).2. To assist also the vice presidents with physical needs such as . Feeding, oral hygiene, .or any other physical need. 8. To encourage the resident to function at his/ her maximum level of ability at all times.During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated, . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call.5. Organize and direct total nursing service on their respective shift.During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts.During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated, . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.During a review of the facility's document titled, Job Description, Director of Nursing, dated 12/29/2025, the document indicated, . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care .During a review of the facility's policy and procedure (P&P) titled, Resident Rights, revision dated 7/9/2025, (continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the P&P indicated, . Policy: The facility shall uphold and protect the rights of all residents without discrimination, consistent with federal and state regulations. Resident Rights Include but Are Not Limited To: I. Dignity and Respect. Be treated with dignity, respect and consideration.During a review of the facility's P&P titled, Respect and Dignity, dated 8/4/2016, the P&P indicated, Respect and dignity: the state of quality of being worthy of honor and respect. The sense of importance and value. [named company] Intentions are to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and/ or enhancement of his or her quality of life, recognizing each president's individuality. protect and promote the rights of all residents. Providing care that supports self- respect of the resident.During a professional reference review retrieved from https://pmc.ncbi.nlm.nih.gov/articles/PMC12300510/ and https://doi.org/10.3390/nu17142256 titled, Hydration Strategies in Older Adults, dated 2025, the professional reference review indicated, . Hydration also plays a key role in physical performance and muscle function. Even minimal fluid loss can negatively impact cognitive performance, emphasizing the need for adequate hydration. Ensuring adequate fluid intake can prevent cognitive decline. While being aware that cognitively impaired individuals may have unique hydration needs, addressing these needs through targeted hydration strategies can enhance cognitive performance and overall wellbeing. Older adults with cognitive impairments, such as dementia, are particularly vulnerable to dehydration. Dehydration is a prevalent yet preventable condition, particularly among older adults, that poses significant health risks if left unaddressed. Healthcare professionals should encourage regular fluid intake in older adults to support optimal physiological functioning (he normal, healthy, and routine physical and chemical processes that occur within an organism's cells, tissues, and organ systems to sustain life ). Education should emphasize starting the day with water and maintaining hydration throughout. To promote adequate hydration, consistent fluid intake should be encouraged, including offering water with meals, between meals, and during medication administration. |

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| Sierra View Homes | 1155 E. Springfield Avenue<br>Reedley, CA 93654 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to meet professional standards of practice for five of ten sampled residents (Resident 8, Resident 13, Resident 29, Resident 39 and Resident 47) when:1. Resident 39's physician orders for Oxygen (O2- a colorless, odorless and tasteless gas essential for life) therapy was incomplete on 9/23/25.This failure had the potential for Resident 39 to be administered incorrect O2 treatment.2. Resident 39's O2 tank was found empty on 2/5/26, and Resident 39 did not receive O2 therapy as ordered by the physician on 2/5/26.This failure placed Resident 39 at risk for experiencing shortness of breath (SOB) and respiratory distress (difficulty breathing).3. Resident 13 and Resident 47's medication from 2/1/26, 2/2/26, and 2/5/26 were not administered according to physician's orders and were still in the medication cart on 2/6/26.This failure had the potential to negatively impact Resident 13 and Resident 47's health and overall well-being, resulting in a decline in their medical condition, ineffective symptom management, and the risk of serious or life-threatening complication due to missed medication doses.4. Resident 8 and Resident 29 did not get timely response from the physicians for significant weight loss faxed on 2/5/26 and 2/10/26.This failure resulted in Resident 8 and Resident 29's significant weight loss to not be addressed in an appropriate time and had the potential for poor wound healing, functional decline and unavoidable weight loss.Findings:<br><br>1. During an observation on 2/5/2026 at 12:16 p.m., Resident 39 was seen in the hallway in front of her room, sitting in her wheelchair with nasal cannula (NC or N/C- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nostrils, and an O2 tank attached to her wheelchair.<br><br>During a review of Resident 39's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information),, dated 2/11/26, the AR indicated Resident 39 was admitted to the facility from acute care hospital on 8/28/25 with diagnoses which included . Hyperlipidemia [abnormally high levels of fats [lipids] in the blood], essential hypertension (high blood pressure that has no single, identifiable medical cause), neuromuscular scoliosis [a sideway curvature of the spine caused by underlying nerve or muscle disorders], multiple sclerosis [a chronic disease where the immune system mistakenly attacks the protective coating (myelin) surrounding nerve fibers in the brain and spinal cord], edema [swelling caused by an abnormal buildup of excess fluid trapped in the body's tissues] .<br><br>During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/24/25, the MDS section C indicated Resident 39 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 09 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS score indicated Resident 39 was moderately impaired.<br><br>During a review of Resident 39's MDS assessment section O Special treatments, Procedures, and Programs, dated 11/24/25, the MDS indicated Resident 39 was on oxygen therapy.<br><br>During a record review of Resident 39's O2 orders, dated 9/23/25 were reviewed, the O2 orders indicated, Oxygen at 4 liters per minute (L/min- a unit of measurement for the flow rate of oxygen)<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | per via N/C-every shift for to help maintain normal oxygen levels. The O2 order did not indicate whether it should be continuous or as needed (PRN).<br><br>During a concurrent interview and record review on 2/9/26 at 3:03 p.m. with Registered Nurse (RN) 1, Resident 39's O2 orders, dated 9/23/25 was reviewed. RN 1 stated the O2 order indicated 4 L/min via NC was started on 9/23/25. RN 1 stated the O2 order was incomplete because it did not specify whether the oxygen was to be administered continuously or PRN. RN 1 stated that since it was not listed as a PRN order, it was interpreted by the licensed nurses (LN)s to be a routine continuous order. RN 1 stated if Resident 39 was on continuous O2, the expectation was for LNs to monitor Resident 39's O2 levels and ensure O2 saturation (measures the percentage of an iron-rich protein found inside red blood cells [hemoglobin] that is carrying oxygen compared to the amount that is not) remained above 90 percent (%-a way of expressing a number as a fraction of 100, representing a part of a whole).<br><br>During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), Resident 39's O2 orders, was reviewed. The DSD stated the O2 orders should clearly specify whether it was a PRN or continuous order, as without that clarification, LNs would not be able to determine whether they were properly following the physician's orders.<br><br>During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), Resident 39's O2 orders, were reviewed. The DON stated and validated that Resident 39's O2 order was incomplete, as it did not specify whether O2 was to be administered continuously or PRN, and the O2 order did not indicate the required oxygen saturation level Resident 39 needed to maintain. The DON stated the O2 order information was important so that LNs could properly follow the physician's direction and provide care in accordance with the ordered treatment. The DON stated the potential outcome of an incomplete order included the risk of errors, including the administration of incorrect treatment.<br><br>2. During an observation on 2/5/2026 at 12:16 p.m., Resident 39 was seen in the hallway in front of her room, sitting in her wheelchair with a NC in her nostrils, and an O2 tank attached to her wheelchair. The O2 tank was noted to be empty and set at 4L/min.<br><br>During a concurrent observation and interview on 2/5/26 at 12:19 p.m. with Certified Nursing Assistant (CNA) 3 in the west wing hallway, Resident 39's O2 tank was observed to be empty and set at 4L/min. CNA 3 stated and validated that the O2 tank was empty and set at 4L/min. CNA 3 stated she would immediately notify the LN to assess the situation.<br><br>During a concurrent observation and interview on 2/5/26 at 12:21 p.m. with the Infection preventionist (IP), the IP stated she had just taken over resident care and the medication cart in the west wing from the outgoing LN. The IP stated and confirmed that the O2 tank was empty and had been set at 4 L/min. The IP stated she would replace the O2 tank immediately.<br><br>During a concurrent interview and record review on 2/9/26 at 3:03 p.m. with RN 1, a picture of Resident 39's O2 tank behind Resident 39's wheelchair was reviewed. RN 1 stated the O2 tank was set at 4 L/min despite being empty. RN 1 stated the expectation when a resident was on O2, LNs should routinely check the O2 tank level to ensure there was an adequate supply of O2 available. RN 1 stated the O2 tank should not have been empty because Resident 39 required O2, had low O2 saturation without it, and exhibited significant difficulty breathing. RN 1 stated the potential outcome of an empty O2 tank included hypoxia (condition where the body's tissues and organs do not receive<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | enough oxygen to function properly) which could lead to further complications.<br><br>During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, a picture of Resident 39's O2 tank behind Resident 39's wheelchair was reviewed. The DSD stated and validated Resident 39's O2 tank was set at 4 L/min despite being empty. The DSD stated that the expectation was the LNs monitored the O2 tank to ensure accurate and continuous administration of O2. The DSD stated failure to do so placed the overall well-being of Resident 39 in jeopardy.<br><br>During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, a picture of Resident 39's O2 tank behind Resident 39's wheelchair was reviewed. The DON stated and validated that Resident 39's O2 Tank was set at 4 L/min and was empty. The DON stated the expectation was LNs routinely checked the O2 tanks to ensure that residents always had an adequate supply of O2. The DON stated in Resident 39's case the physician's O2 order was not followed. The DON stated the potential outcome of an empty O2 tank included hypoxia and low oxygen saturation which could lead to increased illness and a wide range of additional complications.<br><br>During a review of the facility's policy and procedures (P&P) titled, Health Information Management Guideline- Section Record Systems- Guideline for Quality Documentation, undated, the P&P indicated, . G. Physician Orders .6. Drug orders that include: .b. quantity and duration of therapy. C. dosage. D. time of administration.<br><br>During a review of the facility's (P&P) titled, Oxygen Administration, dated 11/13/2009, the P&P indicated, .Responsibility: Licensed Nurse. Purpose: To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues. procedure . 1. check physician order for later flow and method of administration.<br><br>During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . This standard procedure helps prevent incidence of misuse or oxygen deprivation which could worsen the patient's hypoxia and ultimate outcome .<br><br>During a professional reference review retrieved from https://www.nccmerp.org/recommendations-enhance-accuracy-administration-medications titled, Recommendations to Enhance Accuracy of Administration of Medications, dated 3/30/23, the professional reference review from the National Coordinating Council for Medication Error Reporting and Prevention indicated, . any order that in incomplete, illegible, or poses any concern should be clarified before preparation and administration.the right medication, in the right dose, to the right person, by the right route, using the right dosage form, at the right time, for the right reason.<br><br>3. During a concurrent observation and interview on 2/6/2026 at 3:05 p.m. in the west wing hallway with Licensed Vocational Nurse (LVN) 4, unopened prepacked medications were found in the medication cart. LVN 4 stated and validated the unopened prepacked medications belonged to Resident 13 with package date 02/05/26- 8:00 a.m. included Potassium Chloride ER [Extended Release-designed to release active ingredients slowly into the bloodstream over an extended period, providing a steady, consistent dose rather than an immediate spike and drop] 20[mEQ-(milliequivalent) is a unit of measurement in medicine that defines the chemical combining power or electrical activity of potassium ions in a solution]- [quantity (Qty)] 1., Lisinopril [used to (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | treat high blood pressure (hypertension), heart failure, and to improve survival after a heart attack] 40 [Milligram -mg-a metric unit of mass equal to one-thousandth of a gram, used for medicine dosages ]- Qty 1., Metoprolol Succinate ER [a medication used once daily to manage hypertension, and heart failure] 50mg- Qty 1., Sertraline HCl [medication that increases serotonin levels in the central nervous system to treat mental health disorder] 50mg- Qty 1., and Memantine [medication used to treat and improve cognitive function and daily functioning] 10mg- Qty 1. and the unopened prepacked medications belonging to Resident 47 with package dates 02/01/26- 8:00 a.m. included Sertraline HCl 25mg- Qty 1., and 02/02/26- 8:00 a.m. included Sertraline HCl 25mg- Qty 1. LVN 4 stated the process for medication administration required LNs to pull up the medications and administer them to the residents. LVN 4 stated that if a resident was unavailable at the time of administration, the medication should be destroyed or placed in the destruction box and should not remain in the medication cart. LVN 4 stated the presence of medications in the medication cart that should not be there, creates the possibility of those medications being accidentally administered to the incorrect resident or the resident to receive multiple doses. LVN 4 stated the potential outcome of this practice included the risk of a resident being accidentally double dosed.<br><br>During a review of Resident 13's AR, dated 2/11/26, the AR indicated Resident 13 was admitted to the facility from an acute care hospital on 2/28/25 with diagnoses which included . pneumonia [an infection that inflames the air sacs [alveoli] in one or both lungs, causing them to fill with fluid or pus], anemia [blood condition characterized by a shortage of healthy red blood cells, which reduces the blood's ability to carry oxygen to organs and tissues], Alzheimer's disease [a progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple daily tasks], hyperlipidemia [an excess of lipids or fats in your blood], heart failure [condition where the heart muscle is too weak or stiff to pump blood efficiently, failing to meet the body's oxygen needs], essential hypertension [high blood pressure that has no single, identifiable medical cause], presence of cardiac pacemaker [a small, battery-operated, implantable device that acts as a backup to the heart's natural electrical system], depression [a serious, common medical illness characterized by persistent, intense feelings of sadness, low mood, or loss of interest in activities], hypokalemia [abnormally low levels of potassium in the blood, that affects the function of nerves and muscles, particularly the heart] .<br><br>During a review of Resident 13's MDS, dated [DATE], the MDS section C indicated Resident 13 had a BIMS score of 06, which indicated Resident 13 had severe cognitive impairment.<br><br>During a review of Resident 13's Order Summary Report (OSR), the OSR indicated Resident 13 had physician orders for Potassium Chloride ER Oral Tablet Extended Release 20meq (Potassium Chloride)-Give 1 tablet by mouth one time a day related to heart failure. with start date 3/26/25, Lisinopril Oral Tablet 40mg (Lisinopril)- Give 1 tablet by mouth one time a day related to essential (primary) hypertension . with start date 3/27/25, Metoprolol Succinate ER oral tablet extended release 24 hour 50mg (metoprolol succinate)- Give 1 tablet by mouth one time a day related to essential(primary) hypertension . with start date 3/27/25, Sertraline HCl Oral Tablet 50mg (Sertraline HCl)- Give 1 tablet by mouth one time a day related to depression. with start date 3/26/25, Memantine HCl Oral Tablet 5mg (Memantine HCl)- Give 1 tablet by mouth at bedtime related to Alzheimer's disease,. for 1 week then give 2 tablet by mouth two times a day related to Alzheimer's disease.with start date 4/18/25.<br><br>During a review of Resident 47's AR, dated 2/11/26, the AR indicated Resident 47 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which included . hypokalemia, pneumonia, essential primary hypertension, depression .<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 47's MDS, dated [DATE], the MDS section C indicated Resident 47 had a BIMS score of 11, which indicated Resident 47 was moderately impaired.<br><br>During a review of Resident 47's OSR, the OSR indicated Resident 47 had physician orders for Sertraline HCl Oral Tablet 25mg (Sertraline HCl)- Give 1 tablet by mouth one time a day for depression with start date 1/29/26.<br><br>During a concurrent interview and record review on 2/10/26 at 2:35 p.m. with the IP, Resident 13 and Resident 47's OSR and Medication Administration Record (MAR) were reviewed. The IP stated and validated Resident 13 had active physician orders for Potassium Chloride ER 20meq, Lisinopril 40mg, Metoprolol Succinate ER 50mg, Sertraline HCl 50mg, and Memantine 10mg. The IP stated the MAR reflected the medications were checked off as administered on 2/5/26. The IP stated the medication should not have been in the medication cart and she was unable to determine what medications were actually given to Resident 13. The IP stated the expectation from the LNs was that medications were administered as scheduled. The IP stated it was important because Resident 13 required the medications which included blood pressure medications, and antidepressants (prescription medications designed to treat and relieve symptoms such as low mood, hopelessness, and fatigue) and that the medications must be administered timely and as prescribed. The IP stated the potential outcome of medications not being administered as scheduled included complications arising from missed doses, including elevated blood pressure. The IP stated and validated Resident 47 had active physician orders for Sertraline HCL 25mg. The IP stated Resident 47 did not receive the medications dated 2/1/26 and 2/2/26 found in the medication cart, despite the MAR reflecting the medications had been checked off as administered on both days. The IP stated the physician orders required Resident 47 to take the medications as prescribed and the LNs did not follow the physician's orders. The IP stated it was important that the LNs followed the physician's orders because Sertraline was an antidepressant that must be taken consistently in order to be effective. The IP stated the potential outcome of medications not administered to Resident 47 included adverse effects of Resident 47's behavior including lack of motivation, sadness, and mood disturbances. The IP stated the prescribed medications were not administered and could cause Resident 47 to not receive the intended therapeutic benefits of the medication.<br><br>During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, a picture of Resident 13 and Resident 47's unpacked medications were reviewed. The DSD stated the expectation from LNs was that all medications were to be administered to residents on the day they are due. The DSD stated it was important medications were administered as ordered because failure to administer medications as scheduled could result in adverse consequences for Resident 13 and Resident 47. The DSD stated the potential outcome of improper medication administration included the risk of overdose if medications were administered at the wrong time or conversely, the residents would not receive an adequate amount of medication to achieve the intended therapeutic effect.<br><br>During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, a picture of Resident 13 and Resident 47's unpacked medications were reviewed. The DON stated and validated the unpacked medications were not administered to Resident 13 on 2/5/26 and to Resident 47 on 2/1/26 and 2/2/26. The DON stated it was important to follow the physician's orders to ensure the overall wellbeing of the residents. The DON stated the potential outcome of medications not being administered as ordered included illness, depression, hypertension, stroke (medical emergency that happens when something prevents your brain from getting enough blood flow), and conditions that could ultimately lead to death, as well as adverse effects on the residents' mental health and coping abilities.<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's P&P titled, Medication and Treatment Administration, dated 10/30/2003, the P&P indicated, Policy: The complete nursing function of administering drugs entails preparing the individual dose from a dispensed, prepacked container, charting the time, dose of medication and actually administering the dose. The licensed nurse is responsible for selecting the correct dose from supply, knowing how to administer such medication, verifying the identity of the medication, verifying the identity of the resident, monitoring the resident's response to the medication and/ or detecting a possible adverse reaction to the medication or treatment administered. Licensed nurses will administer only medications that they have personally prepared.<br><br>During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated, . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. 3 .gives or supervises giving of all prescribed treatments. 4. notes and transcribe physicians' orders with their appropriate flow through.Knowledge and abilities. 3. Give medication as prescribed with good basic knowledge of side effects of these.5. Organize and direct total nursing service on their respective shift.<br><br>During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts. 3 .gives medication as prescribed .6. Gives and supervises giving of all prescribed treatments. 7. notes and transcribe physicians' orders with their appropriate flow through.Knowledge and abilities. Give medication as prescribed with good basic knowledge of side effects of these.<br><br>During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated, . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.<br><br>During a review of the facility's document titled, Job Description, Director of Nursing, dated 12/29/2025, the document indicated, . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care .<br><br>During a professional reference review retrieved from https://www.ncbi.nlm.nih.gov/books/NBK560654/ titled, Nursing Rights of Medication Administration, dated 9/4/23, the professional reference review indicated, . Nurses have a unique role and responsibility in medication administration, in that they are frequently the final person to check to see that the medication is correctly prescribed and dispensed before administration. It is standard during nursing education to receive instruction on a guide to clinical medication administration and upholding patient safety known as the 'five rights' or 'five R's' of medication administration. Medical errors are a reality . Examples of human error are lack of medical knowledge, lack of attention to detail or care, failing to verify information in an effort to save time, disorganization of workplace or supplies, and miscommunication among healthcare professionals or with a patient.Patient safety and (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | quality of care are essential components of nursing practice and priorities that demand consideration to enable the delivery of high-quality, patient-centered care, and overall well-being. Medical errors are unfortunately very common in clinical practice, and in addition to compromising a patient's personal safety, they can also be extremely costly for hospitals.<br><br>4. During a review of Resident 8's AR dated 2/11/26, the AR indicated Resident 8 was admitted to the facility on [DATE] with diagnoses of difficulty walking, chronic atrial fibrillation (heart arrhythmia characterized by rapid, disorganized, and irregular electrical impulses in the heart's upper chambers (atria), constipation and hypertension (high blood pressure).<br><br>During a review of the Resident 8's fax form Untitled, dated 2/5/26, the fax form indicated,.Registered Dietician [RD] Weekly Review with Recommendations.Significant weight loss [times (x)] 1 month.Recommendation: Recommended increase whole milk to 4 [ounces (oz)] three times a day (TID)] with meals to 8 oz with meals.2. Add weekly weights. No fax was returned and followed up within 24 hours.<br><br>During a review of the Resident 8's fax form Untitled, dated 2/10//26, the fax form indicated,.Dietician Weekly Review with Recommendations.Significant weight loss x 1 month.Recommendation: Recommended increase whole milk to 4 oz. TID with meals to 8 oz with meals.2. Add weekly weights. A second fax was submitted to the physician to notify of the recommendations five days after the first fax.<br><br>During a review of Resident 29's AR, dated 2/11/26, the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses of diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD -irreversible kidney failure) and legal blindness.<br><br>During a review of Resident 29's [Facility Name] Progress Note (PN), dated 2/4/26, the PN indicated, RD Weight Review. [resident (res)] with significant yet noteworthy [weight (wt.)] loss since admission. Discussed in [interdisciplinary Team (IDT)- meeting is a structured, regular gathering of health professionals—typically nurses and RD-who collaborate to create, review, and update comprehensive care plans for residents], res has not been eating [due to (d/t)] disliking minced and moist and d/t blindness and does not know what she is eating staff has obtained waiver from family stating res may eat regular.RD recommendations: 1. Remove [Consistent Carbohydrate (CC) or Renal/Consistent Carbohydrate (RCS) (type of diet order)].2. Continue to monitor weekly weights.<br><br>During a review of the Resident 29's fax form Untitled, dated 2/5/26, the fax form indicated,.Dietician Weekly Review with Recommendations.1 Recommend remove CC/RCS, Renal and cardiac restrictions of diet d/t poor intake. 2. Continue to monitor weekly weights.3. Upgrade textures to regular once wavier has been received. No fax was returned and followed within 24 hours.<br><br>During a review of the Resident 29's fax form Untitled, dated 2/10/26, the fax form indicated,.Dietician Weekly Review with Recommendations.1 Recommend remove CC/RCS, Renal and cardiac restrictions of diet d/t poor intake. 2. Continue to monitor weekly weights.3. Upgrade textures to regular once wavier has been received. A second fax was submitted to the physician to notify of the recommendations five days after the first fax.During a concurrent observation and interview on 2/6/26 at 3:19 p.m. in Resident 29 's room, Resident 29 was in the wheelchair sitting with Family Member (FM) 2 getting ready for lunch. FM 2 stated he was concerned about Resident 29's meal intake. FM 2 stated Resident 29 was blind and should have some finger food. FM 2 stated she<br>(continued on next page) |

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| Sierra View Homes | 1155 E. Springfield Avenue<br>Reedley, CA 93654 |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | struggled to eat and lost weight.<br><br>During a concurrent interview and record review on 2/11/26 at 9:09 a.m. with LVN 2, Resident 29's fax form, dated 2/5/26 was reviewed. LVN 2 stated nurses should have faxed the RD recommendations to the physician after receiving it. LVN 2 stated she faxed Resident 8 and Resident 29's RD recommendations on 2/5/26 and had not received any reply from the physician. LVN 2 stated, We fax the order and we need to follow up. LVN 2 stated sometimes the fax took three to four days for the physician to reply. LVN 2 stated the RD recommendations included monitoring weight loss weekly, and this was needed to keep track and prevent further weight loss. LVN 2 stated the licensed nurses need to keep the physician informed of the RD recommendation to prevent further weight loss. LVN 2 stated residents with weight loss could have poor wound healing and decrease in functional status contributing to hospitalization and unavoidable weight loss.<br><br>During an interview on 2/11/26 at 10:49 a.m. with the RD, the RD stated the nurse should have faxed the weight loss recommendations to the physician. The RD stated the recommendations should have reached the physician and the orders carried out within 24 hours. The RD stated that the weight loss recommendations was discussed with the residents and family members and were agreeable with the new recommendations. The RD stated family members expected the RD recommendations to be changed the same day. The RD stated the family could have lost trust in the medical staff when the recommendations took a long time to be carried out. The RD stated not following up with the recommendations and getting the order in a timely manner could have contributed to further weight loss. The RD stated residents with weight loss could have poor wound healing and functional decline such as muscle weakness. The RD stated residents with further weight loss could have led to hospitalization from poor wound healing. The RD stated the facility should have followed up with the physician to ensure the response was timely.<br><br>During an interview on 2/11/2026 at 1:07 p.m. with the DON, the DON stated we should receive a new physician order within a day. The DON stated, Sometimes he [physicians] is good at responding and we wait till Wednesday to notify the physician in person. The DON stated the facility discussed the weight loss recommendations with family members. The DON stated, We are at the mercy of the physician. The DON stated, When the [RD] recommendations were not addressed residents could continue to have weight loss and they could get sicker. The DON stated, Their [residents] wound would not heal. The DON stated residents could have declined in functional status and put residents at risk for hospitalization.<br><br>During an interview on 2/11/2026 at 1:00 p.m. with the Medical Director (MD-licensed physician responsible for leading clinical services, setting medical policies, and ensuring high-quality care in nursing homes), the MD stat[TRUNCATED] |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards of practice for eight of 16 sampled residents (Resident 9, Resident 11, Resident 36, Resident 39, Resident 55, Resident 6, Resident 7, and Resident 38), when Resident 9, Resident 11, Resident 36, Resident 39, Resident 55, Resident 6, Resident 7, and Resident 38's copy of the Physician Orders for Life-Sustaining Treatment (POLST - a medical order signed by both the patient and medical provider that specifies the types of medical treatment a patient wishes to receive toward the end of life) were incomplete.This failure had the potential for Resident 9, Resident 11, Resident 36, Resident 39, Resident 55, Resident 6, Resident 7, and Resident 38's decisions regarding lifesaving treatment options and end of life wishes to not be honored.Findings<br><br>1. During a concurrent observation and interview on [DATE] at 2:56 p.m. in Resident 36's room, Resident 36 was observed dressed and lying in bed. Resident 36 stated she had been in the facility since [DATE].<br><br>During a review of Resident 36's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 36 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which include . Chronic kidney disease (a gradual loss of kidney function where the kidneys cannot filter the blood as they should), atherosclerotic heart disease of native coronary artery ( condition where plaque (fat, cholesterol, and other substances) builds up inside the original, un-grafted arteries supplying blood to the heart), gastroesophageal reflux disease (GERD- condition where stomach acid frequently flows back into the tube connecting the mouth and stomach [esophagus]), essential hypertension (high blood pressure that has no single, identifiable medical cause), personal history of other mental and behavioral disorders, .<br><br>During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 36 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 11 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS scores indicated Resident 36 was moderately impaired.<br><br>During an observation on [DATE] at 3:35 p.m. in Resident 9's room, Resident 9 was observed dressed and lying in bed with his/her eyes closed.<br><br>During a review of Resident 9's AR, dated [DATE], the AR indicated Resident 9 was admitted to the facility from an assisted living /board and care/group home on [DATE] with diagnoses which include . Acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), epileptic seizures (a sudden, temporary surge of uncontrolled electrical activity in the brain that disrupts normal function), bipolar disorder (chronic (continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from high-energy manic episodes to low-energy depressive episodes), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), .<br><br>During a review of Resident 9's MDS, dated [DATE], the MDS section C indicated Resident 9 had a BIMS score of 03, which indicated Resident 9 had severe cognitive impairment.<br><br>During an observation on [DATE] at 3:35 p.m. in Resident 11's room, Resident 11 was observed dressed, lying in bed, and was unable to respond appropriately to questions asked.<br><br>During a review of Resident 11's AR, dated [DATE], the AR indicated Resident 11 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which include . essential hypertension, gastroesophageal reflux disease, varicose veins (swollen, twisted, and enlarged veins that usually appear blue or dark purple just under the skin's surface, most commonly in the legs) of unspecified lower extremity with ulcer (an open, painful sore on the skin that occurs when surface tissue breaks down) of unspecified sites, alcoholic cirrhosis of liver with ascites (a severe, advanced stage of liver disease caused by long-term alcohol abuse), venous insufficiency (condition where leg vein valves are damaged or weakened, preventing blood from flowing efficiently back to the heart), anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life), .<br><br>During a review of Resident 11's MDS, dated [DATE], the MDS section C indicated Resident 11 had a BIMS score of 07, which indicated Resident 11 had severe cognitive impairment.<br><br>During an observation on [DATE] at 3:35 p.m. in Resident 55's room, Resident 55 was observed dressed and sitting in bed.<br><br>During a review of Resident 55's AR, dated [DATE], the AR indicated Resident 55 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which include . Senile degeneration of brain (the progressive, irreversible breakdown and death of brain cells [neurons] and their connections), hypothyroidism (condition where the butterfly-shaped thyroid gland in the neck does not produce enough thyroid hormones), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), major depressive disorder (a serious, common medical illness characterized by persistent, intense feelings of sadness, low mood, or loss of interest in activities), anxiety disorder, essential hypertension, acute respiratory failure with hypoxia, .<br><br>During a review of Resident 55's MDS, dated [DATE], the MDS section C indicated Resident 55 had a BIMS score of 00, which indicated Resident 55 had severe cognitive impairment.<br><br>During an observation on [DATE] at 12:16 p.m., Resident 39 was seen in the hallway in front of her room and sitting in her wheelchair.<br><br>During a review of Resident 39's AR, dated [DATE], the AR indicated Resident 39 was admitted to the facility from acute care hospital on [DATE] with diagnoses which include . Hyperlipidemia (abnormally high levels of fats [lipids] in the blood), essential hypertension, neuromuscular scoliosis (a sideway curvature of the spine caused by underlying nerve or muscle disorders), multiple sclerosis (a chronic disease where the immune system mistakenly attacks the protective coating [myelin] surrounding nerve fibers in the brain and spinal cord), .<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 39's MDS, dated [DATE], the MDS section C indicated Resident 39 had a BIMS score of 09, which indicated Resident 39 was moderately impaired.<br><br>During a concurrent interview and record review on [DATE] at 3:03 p.m. with Registered Nurse (RN) 1, POLST forms for Residents 9, 11, 36, 39 and 55 were reviewed. The POLST indicated the second page which included, Patient's information (name, date of birth and gender), Supervising Physician's name, Preparer's name/title and phone number were incomplete for Residents 9, 11, 36, 39 and 55. RN 1 stated the POLST was important because it informed medical professionals of the residents' wishes and allowed their legal decision-maker to determine whether they wished to be resuscitated. RN 1 stated the potential outcome of an incomplete POLST included confusion regarding the residents' wishes and a resident who did not wish to be resuscitated could most likely be resuscitated as a result.<br><br>During a concurrent interview and record review on [DATE] at 4:08 p.m. with the Medical Records Custodian (MR), POLST forms for Residents 9, 11, 36, 39 and 55 were reviewed. The POLST indicated the second page which included, Patient's information (name, date of birth and gender), Supervising Physician's name, Preparer's name/title and phone number were incomplete for Residents 9, 11, 36, 39 and 55. The MR stated the purpose of the POLST was to ensure that it was present in the residents' medical record and signed by the physician. The MR stated it was her responsibility to ensure the POLST was signed by the responsible party and physician, however, she typically only reviewed the front of the POLST form. The MR stated regarding the back of the POLST form, she was unaware that it was required to be completed. The MR stated when a resident was transferred out, a copy of the POLST was sent with them however she was unaware that the back portion of the form should also be completed before the resident was sent out. The MR stated proper completion of the POLST was important to protect the facility and to ensure that the residents' information was legally protected and transmitted appropriately. The MR stated the potential outcome of improper completion included the possibility of a family member filing a complaint that the information was sent out without the appropriate signatures or was handled improperly.<br><br>During an interview on [DATE] at 3:15 p.m. with the Director of Nursing (DON), the DON stated the purpose of the POLST was to ensure the residents' wishes were properly communicated when transferring information from one facility to another. The DON stated this was to ensure the residents received care in accordance with their documented wishes. The DON stated the potential outcome of failing to follow the POLST could result in the facility staff providing either too much or too little care as the residents' wishes would not be properly followed.<br><br>During a concurrent observation and interview on [DATE] at 3:16 p.m. in Resident 6's room, Resident 6 was observed dressed and sitting in a wheelchair next to her bed. Resident 6 stated she had been at the facility for a couple of months for getting sick.<br><br>During a review of Resident 6's AR, dated [DATE], the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a condition where brain function is disturbed due to different diseases or toxins [poisons] in the blood), pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), type 2 Diabetes Mellitus, sepsis (a serious condition in which the body responds improperly to an infection), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), atrial fibrillation (an irregular heartbeat), weakness, and anxiety disorder.<br><br>During a review of Resident 6's MDS, dated [DATE], the MDS section C indicated Resident 6 had a<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | BIMS score of 13, which indicated Resident 6 was cognitively intact.<br><br>During a review of Resident 6's Order Summary Report (OSR), dated [DATE], the OSR indicated, .DNR (Do Not Resuscitate) [DNR - do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating) if breathing stops or the heart stops beating].<br><br>During a review of Resident 6's Care Plan (CP), (undated), the CP indicated, .resident code status is DNR.date initiated: [DATE].resident's Advanced Directives [a legal document indicating resident preference on end-of-life treatment decisions] Wishes will be known.date initiated [DATE].staff will follow resident POLST form.date initiated: [DATE].<br><br>During a concurrent interview and record review on [DATE] at 11:47 a.m. with LVN 3, Resident 6's POLST, undated, was reviewed. The POLST indicated no date was entered when the form was prepared, no patient date of birth was entered, section D Information and Signatures, which indicated who the form was discussed with, Patient, or Legally Recognized Decisionmaker was not completed. LVN 3 stated Resident 6's POLST was not dated, and section D was not complete. LVN 3 stated Resident 6's POLST should have been dated. LVN 3 stated section D indicated who the POLST was discussed with for completion of Resident 6's POLST. LVN 3 stated the POLST form informed caregivers of what care to give during a resident's end of life or during an emergency. LVN 3 stated all sections of the POLST should have been completed.<br><br>During a concurrent observation and interview on [DATE] at 3:29 p.m. in Resident 7's room, Resident 7 was observed dressed and lying in bed. Resident 7 stated she had been at the facility for three years due to pneumonia.<br><br>During a review of Resident 7's AR, dated [DATE], the AR indicated Resident 7 was admitted on [DATE] from an acute care hospital with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), pneumonia, anxiety disorder, major depressive disorder single episode, depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life) and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility).<br><br>During a review of Resident 7's MDS, dated [DATE], the MDS section C indicated Resident 7 had a BIMS score of six, which indicated Resident 7 was severely cognitively impaired.<br><br>During a concurrent interview and record review on [DATE] at 11:54 a.m. with LVN 3, Resident 7's POLST, dated [DATE] was reviewed. The POLST indicated, Patient date of birth was not completed, no date of birth listed, and the back side of the POLST, which indicated who completed the POLST and additional contact information was not completed. LVN 3 stated the Resident's date of birth should have been entered to verify it was the right resident and the back side of the POLST was important to be completed so staff would know the contact information of the resident's next of kin. LVN 3 stated the back side of Resident 7's POLST should have been completed.<br><br>During a concurrent observation and interview on [DATE] at 2:58 p.m. in Resident 38's room, Resident 38 was observed dressed, lying in bed with her husband sitting next to bedside table. Resident 38 stated she had been at the facility since [DATE] due to her kidney's shut down. Resident 38 stated she has had six dialysis treatments and just returned from a treatment.<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 38's AR, dated [DATE], the AR indicated Resident 38 was admitted to the facility on [DATE] from an acute care hospital with diagnoses of acute pulmonary edema (a buildup of fluid in the lungs), acute respiratory failure, acute kidney failure, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and depression.<br><br>During a review of Resident 38's MDS, dated [DATE], the MDS section C indicated Resident 38 had a BIMS score of 14, which indicated Resident 38 was cognitively intact.<br><br>During a review of Resident 38's OSR, dated [DATE], the OSR indicated, .CPR (cardiopulmonary Resuscitation) SELECTIVE TREATMENT.<br><br>During a concurrent interview and record review on [DATE] at 4:20 p.m. with the Infection Preventionist (IP), Resident 38's POLST, dated [DATE] was reviewed. The POLST indicated section C Artificially Administered Nutrition was not filled in. The IP stated section C should have been completed as it indicated if Resident 38 would receive artificial nutrition and what type of feeding. The IP stated a POLST was important since it stated the way the resident was to be treated at the resident's end-of-life and if the resident was a Full Code or DNR. The IP stated if the POLST was not complete, staff would not have known what to do and how to treat the residents during their end-of-life or during an emergency.<br><br>During a concurrent interview and record review on [DATE] at 12:00 p.m. with LVN 3, Resident 38's POLST, dated [DATE] was reviewed. The POLST indicated section C Artificially Administered Nutrition was not filled in. LVN 3 stated section C Artificially Administered Nutrition was not completed. LVN 3 stated section C of Resident 38's POLST should have been completed, since it informed staff if Resident 38 wanted tube feeding in case she was not able to eat. LVN 3 stated if Resident 38's POLST was not complete, Resident 38 could have received treatment she did not ask for or wanted during her end-of-life care.<br><br>During an interview on [DATE] at 2:45 p.m. with the Social Services Director (SSD), the SSD stated Admissions will start filling out the POLST form with the residents and the SSD will follow up on obtaining signatures and direct the forms to the physician. The SSD stated the nurses made sure the POLST was complete. The SSD stated the POLST was important in case there was an emergency with the residents and they needed to be sent out, the POLST form went with the resident. The SSD stated the POLST informed staff if a full code or no code was to be implemented for the residents. The SSD stated it was important to know the residents' wishes.<br><br>During an interview on [DATE] at 3:53 p.m. with the MR, the MR stated if there was a planned admission, the POLST was generated out of the Administration Office. The MR stated if she saw the physician, she asked him to sign the POLST. The MR stated she asked the nurses to complete the POLST forms if they were not completed. The MR stated she made sure the completion of the POLSTs were done. The MR stated the POLST was important since it indicated if the residents would have full CPR during an emergency.<br><br>During an interview on [DATE] at 4:29 p.m. with the DON, the DON stated the POLST was the advanced directive for the residents. The DON stated the POLST indicated the medical wishes for the residents' end-of-life care. The DON stated the POLST was communication between facilities to honor the residents' wishes. The DON stated all sections of the POLST should have been completed. The DON stated if the POLST was not complete, there was the potential to affect the end-of-life<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | wishes of the residents or the resident's Responsible Party (RP).<br><br>During a review of the facility's job description document titled, Medical Records Director, dated [DATE], the document indicated, .Duties and Responsibilities: 1. This position reports to the Director of Nursing and is accountable for maintenance and updating patient records in compliance with state and federal regulations.<br><br>During a review of the professional reference titled, Physician Orders for Life-Sustaining Treatment Forms & Instructions (POLST), dated 2026, retrieved from, https://www.[NAME]-[NAME].org/programs/support-services/services/healthcare-ethics/polst.html, the professional reference indicated, .the Physician Orders for Lifeˆ Sustaining Treatment (POLST) is a physician's order that outlines a plan for end of life care reflecting both a patient's preferences and a physician's judgment based on a medical evaluation.the POLST form is completed by a patient 's physician [or by someone who has undergone special training about POLST and who works with the patient's physician] in conjunction with thorough conversation with the patient regarding the patient 's current and future health conditions and treatment preferences. Both the physician and patient must sign the POLST. If the patient lacks capacity to make medical decisions, the patient 's legally recognized decision-maker can participate in both completing and signing the POLST form . |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**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 three of eight sampled residents (Resident 9, Resident 11, and Resident 49) when:1. Resident 9 was on Droplet Precautions (infection control measures designed to prevent the spread of germs (viruses/bacteria) transmitted through large respiratory droplets created by coughing, sneezing, or talking that usually travel short distances (less than 6 feet) and facility staff did not put on appropriate Personal Protective Equipment (PPE- wearable gear and clothing designed to protect individuals from workplace injuries, illnesses, and infections) when entering Resident 9's room.2. A urinal (a portable, handheld, or bedside container used by patients to receive urine) was seen on Resident 11's dresser close to Resident 11's water pitcher.3. Resident 49's nasal cannula (a lightweight, flexible device used to deliver supplemental oxygen or increased airflow to a person's respiratory system) tube was found on the floor.These failures placed residents, staff, and visitors 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:<br><br>1. During an observation on 2/4/2026 at 3:35 p.m. during the initial tour outside Resident 9's room, there was a droplet precaution sign with instructions outside the room door and Resident 9 was in the room, observed to be dressed and lying in bed with his eyes closed. The droplet precaution signage indicated . clean hands including entering . make sure their eyes, nose and mouth are fully covered before room entry . remove face protection before room exit.<br><br>During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 9 was admitted to the facility from an assisted living /board and care/group home on [DATE] with diagnoses which include . Acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), epileptic seizures (a sudden, temporary surge of uncontrolled electrical activity in the brain that disrupts normal function), bipolar disorder (chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from high-energy manic episodes to low-energy depressive episodes), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) .<br><br>During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/8/26, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 03 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS score indicated Resident 9 had severe cognitive impairment.<br><br>During an observation on 2/4/26 at 3:38 p.m., Certified Nursing Assistant (CNA) 1 and CNA 4, entered Resident 9's room with a surgical mask but no goggles.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 2/4/26 at 3:39 p.m. with CNA 4, CNA 4 stated, Droplet precautions required masks, goggles, gloves, and gowns. CNA 4 stated before facility staff went into Resident 9's room, facility staff should sanitize and put on PPE. CNA 4 stated this was important, so facility staff did not get sick or bring it out and get everybody else sick. CNA 4 stated, If everybody got sick, there could be an outbreak.<br><br>During an observation on 2/4/26 at 3:57 p.m. Registered Nurse (RN) 1 entered Resident 9's room with a mask but no goggles.<br><br>During an observation on 2/4/26 at 4:05 p.m., the Social Services Director (SSD) and Maintenance Supervisor (MNT), entered Resident 9's room with a mask but no goggles.<br><br>During an interview on 2/4/26 at 4:42 p.m. with CNA 1, CNA 1 stated droplet precaution meant gown, mask, gloves and goggles should be worn. CNA 1 stated she did not use her goggles. CNA 1 stated she should have been using the goggles as it was important for her safety. CNA stated failure to use goggles could potentially lead to a spread around of the infection<br><br>During an interview on 2/9/26 at 3:57 p.m. with the Infection Preventionist (IP), the IP stated the expectation from facility staff was that anyone going into Resident 9's room should wear a mask and goggles. The IP stated when providing close care, the expectation from facility staff was that anyone going into the room should have a mask, gloves, goggles, and gown. The IP stated the CNAs, the RN, the SSD, and the MNT did not use their goggles, and they did not follow the droplet precaution policy. The IP stated it was important to follow the policy to protect themselves and others. The IP stated this could lead to the spread of infection or whatever illness Resident 9 had.<br><br>During an interview on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), the DSD stated the expectation from facility staff regarding droplet precautions was to put on the mask and goggles outside the room. The DSD stated if there was close contact, gloves and gown should also be worn. The DSD stated this was important to protect the facility staff from getting droplets into their eyes, ears, nose, or mouth and to protect them from getting sick. The DSD stated the potential outcome could be the facility staff got sick and spread the infection.<br><br>During an interview on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), the DON stated the expectation from facility staff was to follow protocol and wear the proper PPE for the proper precaution. The DON stated this was important so that the facility staff did not continue to cross contaminate or spread the infection. The DON stated the potential outcome was that facility staff would risk spreading the infection.<br><br>During a review of the facility's document titled, Job Description, Infection Preventionist IP Nurse, dated 12/29/2025, the document indicated, . Responsible for the facility infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (infectious illnesses caused by bacteria, viruses, parasites, or fungi, spreading directly or indirectly between people, animals, or contaminated environments ) and infection. Oversights of the IPCP which includes . Ensure that local state federal and [OSHA- Occupational Safety and Health Administration] standard and transmission based precautions are to be followed to prevent spread of infection: when and how infections should be used for resident; including the type and duration of the isolation . Assess the need for, develop, and present IPCP in service education for individual departments .<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of the facility's policy and procedure (P&P) titled, Infection prevention and control program, dated 10/30/2024, the P&P indicated, . Policy: An infection prevention and control program (IPCP) is to be established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases an infection. The IPCP is coordinated and overseen by an infection prevention specialist (infection preventionist) . a. policies and procedures are cornerstone of the IPCP. b. policy and procedures reflect the current infection prevention and control standards of practice. Important facets of infection prevention include . Educating staff and ensuring that they adhere to proper techniques and procedures.<br><br>2. During an observation on 2/4/2026 at 3:35 p.m. in Resident 11's room, Resident 11 was observed dressed, lying in bed, and unable to respond appropriately to questions asked. A urinal was noted to be on Resident 11's dresser close to Resident 11's water pitcher.<br><br>During a review of Resident 11's AR, dated 2/11/26, the AR indicated Resident 11 was admitted to the facility from acute care hospital on 6/22/25 with diagnoses which include . essential hypertension (high blood pressure that has no single, identifiable medical cause), gastroesophageal reflux disease (condition where stomach acid frequently flows back into the tube connecting the mouth and stomach [esophagus]), varicose veins (swollen, twisted, and enlarged veins that usually appear blue or dark purple just under the skin's surface, most commonly in the legs) of unspecified lower extremity with ulcer of unspecified sites, alcoholic cirrhosis of liver with ascites (a severe, advanced stage of liver disease caused by long-term alcohol abuse), venous insufficiency (condition where leg vein valves are damaged or weakened, preventing blood from flowing efficiently back to the heart), anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life) .<br><br>During a review of Resident 11's MDS, dated [DATE], the MDS section C indicated Resident 11 had a BIMS score of 07, which indicated Resident 11 had severe cognitive impairment.<br><br>During a review of Resident 11's MDS assessment section GG Functional Abilities, dated 12/22/25, the MDS indicated Resident 11's functional abilities were coded between 01, 02, and 88. Resident 11 was code 01 (dependent: helper does all the effort; resident does none of the effort to complete self-care) for shower/bath self. Resident 11 was code 02 (substantial/ maximal assistance: helper does more than half the effort) for oral hygiene, toilet hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, lying-to-sitting on side of bed, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident 11 was code 88 (not attempted due to medical condition or safety concerns) for sit to stand. The functional abilities code indicated Resident 11 needed substantial/ maximal assistance in 10 abilities, was dependent on facility staff in 1 ability and 1 ability was not attempted due to Resident 11's medical condition or safety concerns.<br><br>During a review of Resident 11's MDS assessment, dated 12/22/25, the MDS section H indicated Resident 11's Bladder and Bowel function included Resident 11 was occasionally (less than 7 episodes of incontinence) for urinary continence (the inability to control when you urinate or have a bowel movement). Resident 11 was frequently incontinent (2 or more episodes of continence bowel movement) for bowel continence.<br><br>During a concurrent observation and interview on 2/4/26 at 3:38 p.m. with CNA 4, Resident 11's urinal was seen on the dresser close to the water pitcher. CNA 4 stated Resident 11 could get up and go to the bathroom but if Resident 11 did not want to get up, he could use the urinal. CNA 4 stated the urinal should not be on the dresser. CNA 4 stated the urinal should be by the bedside so Resident 11 could (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | reach it. CNA 4 stated this was important because if the urinal was full, it could spill and there could be cross contamination with the water. CNA 4 stated Resident 11 could also fall trying to reach the urinal.<br><br>During a concurrent observation and interview on 2/4/26 at 3:57 p.m. with RN 1, Resident 11's urinal was seen on the dresser. RN 1 stated and validated the urinal was on the dresser. RN 1 stated the urinal should be within Resident 11's reach. RN 1 stated if Resident 11 was unable to reach the urinal it could spill. RN 1 stated the urinal should be placed lower. RN 1 stated this was important so that Resident 11 could use the urinal to urinate. RN 1 stated if the urinal content spilled, it could be a mess and there could cause cross contamination. RN 1 stated the potential outcome could be unsanitary conditions.<br><br>During a concurrent interview and record review on 2/9/26 at 3:57 p.m. with the IP, pictures of Resident 11's urinal close to the water pitcher were reviewed. The IP stated the facility staff were not supposed to put the urinal on the dresser. The IP stated the urinal should be in the bathroom or at the foot side of the bed and if Resident 11 wanted to use it, he could use it independently. The IP stated this was important because it could lead to cross contamination. The IP stated the urinal was dirty and the facility staff put other things on the resident's dresser. The IP stated the urinal could also fall and urine could spill everywhere. The IP stated since it was body fluid, the facility staff would not know what was in it and that could lead to infection or harm to the skin.<br><br>During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, pictures of Resident 11's urinal close to the water pitcher were reviewed. The DSD stated the expectation from the facility staff was that the urinal should be separated from the water because it was an infection control issue.<br><br>During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, pictures of Resident 11's urinal close to the water pitcher were reviewed. The DON stated the expectation from facility staff was that the urinal should be dumped and cleaned and put in the drawer. The DON stated this was important to prevent infection and contamination. The DON stated the potential outcome could be the urine could spill and fall on Resident 11.<br><br>During a review of the facility's document titled, Job Description, Certified Nurse Assistant (CNA), dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A certified nurse assistant is responsible for the direct care of the group of residents assigned, and provides the activities of daily living care, including ADL documentation, and psychosocial services [support actions that address the mental, emotional, social, and spiritual needs of individuals, particularly when facing illness, crisis, or disability].2. To assist also the vice presidents with physical needs such as . Feeding, oral hygiene, .or any other physical need. 8. To encourage the resident to function at his/ her maximum level of ability at all times.<br><br>During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated, . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call.5. Organize and direct total nursing service on their respective shift.<br><br>During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts.<br><br>During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated, . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.<br><br>During a review of the facility's document titled, Job Description, Director of Nursing, dated 12/29/2025, the document indicated, . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care .<br><br>During a review of the facility's P&P titled, Resident Rights, revision dated 7/9/2025, the P&P indicated, . Policy: The facility shall uphold and protect the rights of all residents without discrimination, consistent with federal and state regulations. Resident Rights Include but Are Not Limited To: I. Dignity and Respect. Be treated with dignity, respect and consideration.<br><br>During a review of the facility's P&P titled, Respect and Dignity, dated 8/4/2016, the P&P indicated, Respect and dignity: the state of quality of being worthy of honor and respect. The sense of importance and value. [named company] Intentions are to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance and/or enhancement of his or her quality of life, recognizing each president's individuality. protect and promote the rights of all residents. Providing care that supports self- respect of the resident.<br><br>3. During an observation on 2/4/26 at 3:47 p.m. in Resident 49's room, a nasal cannula tube was found on the floor.<br><br>During a concurrent observation and interview on 2/4/26 at 4:10 p.m. with CNA 5, CNA 5 confirmed the nasal cannula was on the floor. CNA 5 stated, It should have been wrapped around the oxygen concentrator on the handle, so it won't be on the floor. CNA 5 stated the nasal cannula tube should not have been on the floor. CNA 5 stated Resident 49 could have had cross-contamination if the nasal cannula was used after it was found on the floor and was dirty. CNA 5 stated Resident 49 could have gotten a respiratory infection. CNA 5 stated, I should have thrown it away and notified the nurse. CNA 5 stated she started working two to three months ago and did not remember having an in-service on the nasal cannula storage.<br><br>During a review of Resident 49's AR, dated 2/11/26, the AR indicated Resident 49 was admitted to the facility on [DATE] with diagnoses of Alzheimer's Disease ( a disease characterized by a progressive decline in mental abilities), Hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormones to meet the body's needs), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) and pulmonary edema (condition characterized by excess fluid accumulation in the lung's air sacs (alveoli), severely impairing breathing and oxygen exchange).<br><br>During a review of Resident 49's MDS, dated [DATE], the MDS section C indicated Resident 49 had a<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | BIMS score of 00, which indicated Resident 49 was cognitively impaired.<br><br>During a review of Resident 49's Order Summary (OS-a legally required, dated, and signed document containing specific directives for a patient's medical treatment, including medication, dosages, tests, and care instructions), dated 4/18/25, the OS indicated, Oxygen at 2 [ liters (L)- a metric unit of capacity] per nasal cannula [as needed (prn)] [shortness of breath (sob)].<br><br>During an interview on 2/9/26 at 5:04 p.m. with the IP, the IP stated the nasal cannula tube should always be stored in a bag when not in use. The IP stated it was all staff member's responsibility to make sure the nasal cannula was not on the floor. The IP stated the residents were at risk for cross-contamination of their nasal cannulas when the nasal cannula was on the floor. The IP stated residents could have used the nasal cannula tubing that was once on the floor and could have a respiratory infection. The IP stated residents who were dependent on oxygen could have worsening health from a respiratory infection. The IP stated she was not sure when the last in-service was done about nasal cannulas storage or infection prevention.<br><br>During an interview on 2/11/26 at 12:59 p.m. with the DON, the DON stated the nasal cannula tubes should be stored in bags when not used. The DON stated it should not be wrapped around the concentrator or on the floor. The DON stated it was important to store items properly to prevent cross-contamination. The DON stated residents were at risk for a respiratory infection from cross-contamination. The DON stated all staff were responsible for ensuring nasal cannulas w stored properly when residents were not using it.<br><br>During a review of the facility's Inservice Meeting Minutes titled, Oxygen is a Medicine and Poses risks for Infection and safety, undated, the in-service indicated, .All healthcare provider.tubing is kept in the bags provided on the concentrators and not dropped or left on the floor when not in use.<br><br>During a review of the professional reference titled, Tips for Meeting Respiratory and Tracheostomy Requirements in Skilled Nursing Facilities, undated, retrieved from, https://www.ahcancal.org/Quality/Clinical-Practice/Documents/Tips%20for%20Respiratory%20Requirement, the reference indicated, . follow the facility's policy on proper storage of respiratory equipment [e.g., masks, tubing, continuous positive airway pressure, oxygen tanks] . if Manufacturer's Instructions for Use (MIFU) states specific frequency to change, ensure the equipment [e.g., oxygen cannula/tubing] is consistently labeled [date/initials], and the resident's treatment records include orders or documentation for regular cannula changes. Any lapses can increase the risk of infection and indicate a failure to follow facility policy and physician orders . bagging or covering equipment when not in use . respiratory equipment must remain clean, do not allow equipment to touch the floor, bedside table, trash bin, etc. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure professional standards of practice were in place for unnecessary medications for two of eight sampled residents (Resident 2, and Resident 7), when:1. Pharmacy recommendations to include resident specific symptoms and/or behaviors which should indicate the reason these residents were being treated with the prescribed antipsychotic (a medication that affects brain activities associated with mental processes and behavior used to treat a collection of symptoms that affect your ability to tell what's real and what is not) and psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications were not listed in Resident 2 and Resident 7's physician's orders for the medications.This failure had the potential for Resident 2 and Resident 7 to be prescribed unnecessary medications due to no monitoring of the resident specific symptoms and/or behaviors they were being prescribed antipsychotic and psychotropic medications for.2. Resident 2 and Resident 7 did not have specific non-pharmacological interventions (any intervention intended to improve the health or the well-being of individuals that do not involve the use of any drugs or medicine) documented prior to the use of psychotropic medications.This failure had the potential for Resident 2 and Resident 7 to be prescribed unnecessary medications due to not having appropriate non-pharmacological interventions implemented prior to administering psychotropic and antipsychotic medications.Findings:1. During a concurrent observation and interview on 2/4/26 at 2:20 p.m. in Resident 2's room, Resident 2 was observed dressed, lying in bed with his lower legs elevated. Resident 2 stated he had been at the facility for nine years because it was a retirement home and he was a retired man.During a review of Resident 2's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/1/26, the AR indicated Resident 2 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (when the blood sugar levels in the body are too high), 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), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/15/24, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) 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 suggested Resident 2 was cognitively intact.During a concurrent interview and record review on 2/9/26 at 4:30 p.m. with the Infection Preventionist (IP), Resident 2's physician orders titled, Medication Review Report, dated 2/11/26 was reviewed. The Medication Review Report indicated, .(brand name antipsychotic medication) oral tablet 5 [milligrams (mg )-unit of measurement] [olanzapine - an antipsychotic medication used to treat schizophrenia] give 0.5 tablet by mouth in the evening for schizophrenia related to paranoid schizophrenia . order status . active . order date 10/23/24.start date.10/23/24. The IP stated the physician order for Resident 2's antipsychotic medication should have had more specific indications for use.During a review of Resident 2's Consultant Pharmacist's (PC) MRR Review Report (MRR), dated Jan. 2026, the MRR indicated, (continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | .[brand name medication] 5 mg 0.5 tablet [orally] [at bedtime] for schizophrenia related to paranoid schizophrenia . change order to [brand name medication] 5 mg 0.5 tablet [orally] [at bedtime] for paranoid schizophrenia [manifested by (m/b)] one of the following . hallucinations [a sight, sound, smell, taste, or touch that a person believes to be real but is not real] . combativeness [an eagerness to fight or argue]. delusions [a mental condition with false beliefs or judgment about external reality]. irritability with aggression. The recommendation had fax written in red with no documentation of the physician's response or change in the order.During an interview on 2/10/26 at 4:29 p.m. with the Director of Nursing (DON), the DON stated new physician orders were audited by the Medical Records (MR) department and the MR followed up with the physician for any clarification or issues with the orders. The DON stated the nurses were responsible for verifying the order was complete. The DON stated when nurses documented the resident's weekly progress notes, the nurses should have been checking the resident's care plans and physician orders. The DON stated if there was no clear order, staff could have been giving unnecessary medications.During a concurrent observation and interview on 2/4/26 at 3:29 p.m. in Resident 7's room, Resident 7 was observed dressed and lying in bed. Resident 7 stated she had been at the facility for three years due to pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid).During a review of Resident 7's AR, dated 2/10/26, the AR indicated Resident 7 was admitted on [DATE] from an acute care hospital with diagnoses of COPD, pneumonia, anxiety disorder, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities) single episode, depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life) and rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility).During a review of Resident 7's MDS, dated 1/11/26, the MDS section C indicated Resident 7 had a BIMS score of six, which indicated Resident 7 was severely cognitively impaired.During a concurrent interview and record review on 2/9/26 at 4:30 p.m. with the IP, Resident 7's Order Summary Report (OSR), dated 2/10/26 was reviewed. The OSR indicated, .aripiprazole [an antipsychotic medication used to manage and treat schizophrenia and major depressive disorder] tablet 10mg give 1 tablet by mouth one time a day related to major depressive disorder, single episode, unspecified.order status active . order date 01/07/2026.start date 01/08/2026.mirtazapine [a drug used to treat depression] tablet 7.5 mg give 1 tablet by mouth at bed time related to depression, unspecified.sertraline hydrochloride [HCl][a medication used to treat depression and anxiety] tablet 100 mg give 1 tablet by mouth one time a day for depression. The IP stated the order for Resident 7's antidepressant medications should have had more specific indications for use and supplemental documentation to see how the medication was working.During a concurrent interview and record review on 2/10/26 at 4:29 p.m. with the Director of Nursing (DON), Resident 7's OSR, dated 2/10/26 was reviewed. The OSR indicated, .aripiprazole tablet 10mg give 1 tablet by mouth one time a day related to major depressive disorder, single episode, unspecified.order status active . order date 01/07/2026.start date 01/08/2026.mirtazapine tablet 7.5 mg give 1 tablet by mouth at bed time related to depression, unspecified.sertraline HCl tablet 100 mg give 1 tablet by mouth one time a day for depression. The DON stated there were no manifestations listed for Resident 7's orders for antidepressants (medications used to treat depression). The DON stated the nurses were responsible for verifying the physician orders were complete. The DON stated when nurses documented the resident's weekly progress notes, the nurses should have been checking the resident's care plans and physician orders. The DON stated if there was no clear order, staff could have been giving unnecessary medications.During a review of Resident 7's Care Plan Report (CP), the CP indicated, .[Resident name] uses antidepressant medication related to [r/t] depression . date initiated: 04/06/2024. revision on: 01/13/2026. administer antidepressant medications as ordered by physician. Monitor/document side effects and effectiveness Q [every] Shift.date initiated: 04/06/2024. No monitoring for target behaviors was listed on Resident 7's CP.During a review of Resident 7's<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Consultant Pharmacist's (PC) MRR Review Report (MRR), dated Jan. 2026, the MRR indicated, .[brand name medication] 10 mg PO [orally] daily for major depressive disorder, single episode, unspecified.mirtazapine 7.5 mg PO [at bedtime (QHS)] for depression, unspecified. sertraline 100 mg PO daily for depression . change order for [brand name medication] 10 mg 0.5 PO daily for major depressive disorder m/b one of the following lack of motivation.crying.self-isolation.feelings of helplessness.change the order for sertraline to sertraline 100 mg daily for major depressive disorder m/b one of the following .lack of motivation.crying.self-isolation.feelings of helplessness.change the order for mirtazapine to mirtazapine 7.5 mg PO QHS for major depressive disorder m/b poor appetite (eating less than 50% of meals). The recommendation had fax written in red with no documentation of the physician's response or change in the orders.During a review of the Consultant Pharmacist's Medication Regimen Review Report (MRR), titled Psychotropic Medication Orders, dated Jan. 2026, the Report indicated, .CMS requires target symptoms/behaviors for psychotropic medications. These symptoms/behaviors must be RESIDENT SPECIFIC and include what exact behavior is being treated. They should be observable, measurable, functionally relevant and trackable over time.During an interview on 2/11/26 at 9:58 a.m. with the PC, the PC stated once recommendations were made during the monthly MRR, she followed up the following month to see if any response was received or changes made by the physician. The PC stated there were no residents with issues on her recommendations.During a concurrent interview and record review on 2/11/26 at 12:13 p.m. with the DON, the PC MRR binder, dated Jan. 2026 was reviewed. The MRR indicated Pharmacist recommendations and Fax written in red by facility staff had no notation of MD response. The DON stated she started the process for communication with the physician and noted in red fax and will send a fax to the physician with the PC's recommendations. The DON stated the physician response time depended on the physicians. The DON stated her expectation was to have a physician response as soon as possible or by the end of the week.During an interview on 2/11/26 at 1:25 p.m. with the Medical Director (MD), the MD stated the diagnoses symptoms are what the medications were prescribed for. The MD stated she did not write the symptoms in her orders, that she never had, and it was not required. The MD stated she did not check the transcribed orders, she trusted staff to write the orders appropriately. The MD stated her response to faxes was several days. For emergencies staff could have called her as she was available for a quicker response 24/7 (24-hours per day/seven days a week).During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Policy and Procedure, dated 1/18/24, the P&P indicated, .the purpose of the Psychotropic Medication Policy and Procedure is to develop a facility system to ensure a resident is not given a psychotropic medication unless a comprehensive assessment which identifies clear indications and parameters for use.During a review of the facility's P&P titled, Psychotherapeutic Medication Review, dated 11/28/2012, indicated, .the targeted behavior will be clearly and specifically identified and monitored every shift.2. During a concurrent interview and record review on 2/9/26 at 4:30 p.m. with the IP, Resident 7's MAR, dated 2/11/26 was reviewed. The MAR indicated, .non-pharmacological interventions for agitation, depression, lack of motivation, sadness/crying resident will be offered the following interventions: orientation and/or redirection.provided quiet, calm environment, music program, 1 on 1 attention, offered daily activities, offered daily [Rehabilitative Nursing Assistant (RNA)]/exercise routine every shift for depression.start date. 01/16/2026. The days of the week and monitoring times of .day.evening.night. had a check mark with initials of the nurse who performed the charting. There was no indication which intervention(s) were attempted. The IP stated the non-pharmacological interventions should have had numbers next to each intervention to help indicate which intervention was implemented, just a check off does not specify what interventions were implemented. The IP stated non-pharmacological interventions helped staff to know which interventions to adjust and helped create a resident-specific care plan for the residents.During an interview on 2/10/26 at 4:36 p.m. with the DON, the DON stated only documenting a check mark on Resident 2 and Resident 7's MAR did not specify which intervention was implemented. The DON<br>(continued on next page) |

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| Sierra View Homes | 1155 E. Springfield Avenue<br>Reedley, CA 93654 |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated if there was no clear physician's order for monitoring the effectiveness of non-pharmacological interventions, there was a risk of giving unnecessary medications to the residents.During a review of the facility's P&P titled, Psychotropic Medication Policy and Procedure, dated 1/18/24, the P&P indicated, .the purpose of the Psychotropic Medication Policy and Procedure is to develop a facility system to ensure a resident is not given a psychotropic medication unless a comprehensive assessment which identifies clear indications and parameters for use.non-pharmacological interventions care plans and individualized plans of care will be utilized. Non-pharmacological interventions are utilized to decrease or discontinue psychotropic medications and limit PRN [as needed] use.During a review of the facility document titled, Health Information Management Guidelines, undated, the document indicated, .each resident's drug regimen must be free from unnecessary drugs. Unnecessary drugs are defined as those given in excessive doses, for excessive periods of time without adequate monitoring, or in the absence of a diagnoses or reason supporting the necessity of the drug.documentation in the clinical record must justify the use of psychoactive drugs [a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior] by showing evidence that the resident has a specific condition, with specific behaviors listed.all interventions used to control the behavior prior to medicating. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of eight sampled residents (Resident 2), received a Level II Pre-admission Screening and Resident Review (PASRR - an evaluation for individuals suspected of having a Serious Mental Illness [SMI] or Intellectual/Developmental Disability [I/DD]/Related Condition [RC]- to determine if they needed specialized services, ensuring placement in the least restrictive setting) evaluation by the designated entity to determine if SMI, ID/DD/RC conditions were present when, Resident 2, who had a diagnosis of schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly) and had a PASRR Level I screening indicating Resident 2 had no diagnosis of schizophrenia which resulted in a negative Level I result for SMI.This failure resulted in Resident 2 not receiving the required PASRR level II screening which had the potential to result in missed identification of specialized services needed and placed Resident 2 at risk for delayed treatments.Findings:During a concurrent observation and interview on 2/4/26 at 2:20 p.m. in Resident 2's room, Resident 2 was observed dressed, lying in bed with his lower legs elevated. Resident 2 stated he had been at the facility for nine years because it was a retirement home and he was a retired man.During a review of Resident 2's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/1/26, the AR indicated Resident 2 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of schizophrenia, Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), diabetes mellitus (when the blood sugar levels in the body are too high), 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), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/15/24, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) 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 suggested Resident 2 was cognitively intact.During a review of Resident 2's MDS, dated 4/15/24, the MDS section GG indicated Resident 2 needed partial to moderate assistance with his Activities of Daily Living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves).During a review of Resident 2's MDS, dated 4/15/24, the MDS section I indicated Resident 2 had diagnoses of Alzheimer's disease, depression, and schizophrenia.During a review of Resident 2's MDS, dated 4/15/24, the MDS section N indicated Resident 2 was taking antipsychotic (a medication that affects brain activities associated with mental processes and behavior used to treat a collection of symptoms that affect your ability to tell what's real and what is not) and antianxiety high-risk drug class medications.During a review of Resident 2's physician orders titled, Medication Review Report, dated 2/11/26, the Medication Review Report indicated, .(brand name antipsychotic medication) oral tablet 5 milligrams [mg -unit of measurement] [olanzapine -an antipsychotic medication used to treat schizophrenia] give 0.5 tablet by mouth in the evening for schizophrenia related to paranoid schizophrenia . order status . active . order date 10/23/24.start date.10/23/24.During a review of Resident 2's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 12/09/21, the PASRR indicated .does the individual have a diagnosed mental disorder such as depression, anxiety, panic, schizophrenia/schizoaffective disorder, psychotic, delusional, and/or mood disorder? . No.the<br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | individual has been prescribed psychotropic [a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior] medications for mental illness.No.During a concurrent interview and record review on 2/9/26 at 5:00 p.m. with the Director of Staff Development (DSD), Resident 2's PASRR, dated 12/09/2021 was reviewed. The PASRR indicated Resident 2 did not have a diagnosis of schizophrenia and did not take psychotropic medications for mental illness. The DSD stated Resident 2 had a diagnosis of schizophrenia and question 10, which indicated if a resident had a diagnosis of schizophrenia, should have been marked Yes. The DSD stated marking yes for question 10 would have triggered a Level II PASRR screening. The DSD stated the PASRR screening evaluated if a resident was receiving accurate care for mental conditions that might have required additional care that the facility was not able to provide. The DSD stated if a Level II screening was triggered, the facility expected the Department of Healthcare Services (DHCS) to contact the facility and request documentation to see if additional care was needed. The DSD stated the Level II screening was able to determine if the resident was able to be in the facility. The DSD stated if the resident triggered a Level II evaluation that was not completed, there was a risk of possible injury to other residents as well as to themselves due to the lack of adequate care.During an interview on 2/10/26 at 4:29 p.m. with the Director of Nursing (DON), the DON stated staff should have been checking if the resident had a completed PASRR before being admitted to the facility from the hospital. The DON stated the facility made sure if a level II screening was needed. The DON stated her expectations were that the residents had a Level I screening and if needed, a Level II screening completed. The DON stated if a resident had some mental illness or mental diagnosis, the PASRR was needed to verify the facility was able to provide the type of care the resident needed. The DON stated if a Level II PASRR screening was not done, the resident might not have had adequate care for their diagnosis.During a review of the facility's policy and procedure (P&P) titled, PASRR Policy and Procedure, dated 4/4/23, the P&P indicated, .a level I Screening is used to identify if an individual has, or is suspected of having, a PASRR condition, i.e., SMI, ID/DD, or RC. If the Level 1 Screening in either scenario is positive for an individual as having, or is suspected of having a PASRR condition, then a Level 2 Evaluation will be performed, and a Determination made.During a review of the professional reference titled, Preadmission Screening and Resident Review, dated 2026, retrieved from, https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx, indicated, .the California Department of Health Care Services (DHCS), PASRR Section is responsible for determining if individuals with serious mental illness (SMI) and/or intellectual/developmental disability (ID/DD) or related conditions (RC) require .nursing facility services, considering the least restrictive setting .specialized services .During a review of the professional reference titled, Preadmission Screening and Resident Review, (undated), retrieved from, https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-scre indicated, . Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care .evaluate all applicants for serious mental illness (SMI) and/or intellectual disability (ID) .offered all applicants the most appropriate setting for their needs [in the community, a nursing facility, or acute care settings] .provide all applicants the services they need in those settings .PASRR can also advance person-centered care planning by assuring that psychological, psychiatric, and functional needs are considered along with personal goals and preferences in planning long-term care . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan (a tailored document summarizing a person's health conditions, care needs, medications, and goals to ensure consistent care and improve quality of life) was developed and implemented for one of five sampled residents (Resident 49), when Resident 49 had an oxygen (a prescribed treatment that provides supplemental oxygen to individuals with low blood oxygen levels) order that started on 4/18/25.This failure had the potential for Resident 49's oxygen needs not be monitored, revised, and met which could cause increase in shortness of breath.Findings:During an observation on 2/4/26 at 3:47 p.m. in Resident 49's room, an oxygen concentrator was next to the bed with the oxygen tubing wrapped on the side rail and nasal cannula (a lightweight, flexible medical device used to deliver supplemental oxygen or increased airflow directly into a patient's nostrils via two small prongs) on the floor.During a concurrent interview and record review on 2/9/26 at 4:47 p.m. with the Infection Preventionist (IP), the IP stated Resident 49 was admitted on [DATE]. The IP stated Resident 49's oxygen was at two liters per minute (LPM-a unit of volumetric flow rate that measures the volume of liquid or gas passing through a point in one minute) as needed which started on 4/18/25. The IP stated Resident 49's nursing note indicated her oxygen saturation was in the 80's on 1/31/26. The IP stated Resident 49 did not have a care plan. The IP stated Resident 49 should have an initial care plan on 4/18/25 when the oxygen order was ordered by the physician. The IP stated the care plan should be revised every three months to meet the needs of Resident 49. The IP stated on 1/31/26 Resident 49's had a change in condition and the care plan for the oxygen should have been revised. The IP stated there should have been a revision to the care plan for Resident 49's low oxygen saturation. The IP stated it was important to develop an initial care plan so nurses would know how to provide care for residents and for communication. The IP stated each resident's needs were dependent on the care plan. The IP stated we should have monitored the residents according to the care plan. The IP stated we provide care for the residents according to the care plan. The IP stated nurses should close out the care plan when the issues or needs of the residents were resolved. The IP stated nurses should be revising and updating ongoing care plans. The IP stated revisions and updates were not done for Resident 49's oxygen needs.During an interview on 2/11/26 at 1:02 p.m. with the Director of Nursing (DON) the DON stated the care plan should have been done with all orders. The DON stated nurses should have created the care plan immediately or by end of the day. The DON stated we want to follow the care plan to provide correct care for the residents. The DON stated, We want it to be a comprehensive. The DON stated resident's needs could not be met without a care plan. The DON stated there could be cracks with the care of the residents without a care plan. The DON stated staff would not be providing correct care for the residents. The DON stated all nurses were responsible for the care plan. During a review of Resident 49's admission Record (AR-a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 49 was admitted to the facility 11/17/20 with diagnoses of Alzheimer's Disease ( a disease characterized by a progressive decline in mental abilities), Hypothyroidism (a condition where the thyroid gland does not produce enough thyroid hormones to meet the body's needs), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) and pulmonary edema (condition characterized by excess fluid accumulation in the lung's air sacs, severely impair breathing and oxygen exchange).During a review of Resident 49'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 2/12/26, the MDS section C indicated Resident 49 had a Brief Interview for Mental Status (BIMS - a test given by<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medical professionals to determine cognitive understanding on a scale of 1-15 ) score of 00 (a score of 00-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 49 was cognitively impaired.During a review of the facility's policy and procedure (P&P) title, Resident Care Plans, dated 11/20/2017, the P&P indicated, .Individualized care of each resident care plan flow from unique list of diagnosis and specific needs. the care plans allow for continuity of care and ongoing communication in the residents' care.the care plans expanded as the resident's needs are identified.the care identified the concerns, the goal and interventions.Care plans are reviewed weekly and upon and condition on changes or order changes, the care plan is updated.updating consists of revision date and the information updated. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, and record review, the facility failed to follow the policy and procedure (P&P) to ensure the care plans (CP) were reviewed and revised for one of eight sampled residents (Resident 39) when:The CP for Resident 39 was not reviewed and revised after Resident 39 had a change in physician's order for oxygen (O2- a colorless, odorless and tasteless gas essential for life) therapy from 2 liters per minute (L/min- a unit of measurement for the flow rate of oxygen) to 4L/min on 9/23/25.Findings:During a concurrent observation and interview on 2/5/2026 at 12:16 p.m., Resident 39 was seen in the hallway in front of her room and sitting in her wheelchair with a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nostrils, and an O2 tank attached to her wheelchair. The O2 tank was set to 4L/min.During a review of Resident 39's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 39 was admitted to the facility from acute care hospital on 8/28/25 with diagnoses which include . Hyperlipidemia [abnormally high levels of fats (lipids) in the blood], essential hypertension (high blood pressure that has no single, identifiable medical cause) , neuromuscular scoliosis [a sideway curvature of the spine caused by underlying nerve or muscle disorders], multiple sclerosis [a chronic disease where the immune system mistakenly attacks the protective coating (myelin) surrounding nerve fibers in the brain and spinal cord], edema [swelling caused by an abnormal buildup of excess fluid trapped in the body's tissues] .During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/24/25, the MDS section C indicated Resident 39 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 09 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS score indicated Resident 39 was moderately impaired.During a review of Resident 39's MDS assessment section O Special treatments, Procedures, and Programs, dated 11/24/25, the MDS indicated Resident 39 was on oxygen therapy while as a resident.During a record review of Resident 39's medical record, dated 2/5/26 at 11:32 a.m., Resident 39's physician's O2 orders, dated 8/28/25 and 9/23/25 and Resident 39's O2 CP, dated 9/5/25 were reviewed. The O2 order indicated Resident 39 had an initial physician order for O2 at 2L/min per via NC dated 8/28/25 at 11:50 p.m., the 2L/min via NC O2 order was discontinued on 9/23/25 at 9:09 p.m. with reason being, need to increase oxygen to maintain normal levels. The O2 order on 9/23/25 indicated, Oxygen at 4 L/min per via N/C-every shift for to help maintain normal oxygen levels. The CP indicated Resident 39 had interventions that included O2 as ordered PRN 2L via N/C-check O2 saturation as of 2/5/26.During a concurrent interview and record review on 2/10/26 at 2:35 p.m. with the Infection preventionist (IP), Resident 39's O2 orders, dated 9/23/25 and CP, dated 9/5/25 were reviewed. The IP stated the O2 order was updated to 4 L/min on 9/23/25 after the previous O2 order for O2 at 2 L/min via nasal cannula was discontinued on 9/23/25, having been in effect since 8/28/25. The IP stated the CP indicated Resident 39 was using oxygen therapy related to shortness of breath, with the intervention documenting O2 as ordered 2L/min via NC as needed (PRN). The IP stated the CP was not updated to reflect the new order of 4 L/min. The IP stated there was no revised care plan in place for the 4L/min O2 order. The IP stated when a new order was received it was the responsibility of all licensed nurses (LN) to initiate and update the CP immediately. The IP stated the expectation when a change in residents' condition occurred would be that LNs should address the problem and initiate a care plan update without delay. The IP stated it was important in order to ensure that proper care was provided to Resident 39, interventions were<br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | implemented and LNs were able to monitor whether those interventions were effective. The IP stated the potential outcome of a CP that was not updated included LNs being unable to determine whether the current interventions were working.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), Resident 39's O2 orders, dated 9/23/25 and CP, dated 9/5/25 were reviewed. The DON stated the CP reflected an O2 order of 2L/min which was no longer consistent with the current physician's order. The DON stated the expectation from LNs was that the CP accurately reflects the current plan of care for Resident 39 and the CP should have been updated to reflect the new order. The DON stated it was important so that all LNs were aware of the exact and current plan of care for Resident 39. The DON stated the potential outcome of the CP not being updated included the risk of a medication error.During a review of the facility's policy and procedure (P&P) titled, Resident Care Plan, dated 11/20/2017, the P&P indicated, . It is the policy of [named company] to provide direction for individualized care of each resident. Care plans flow from unique list of diagnosis and specific needs. The care plans allow for continuity of care and ongoing open communication in the residents' care. Procedure: Resident care plans initiated upon admission of the resident. The care plans expanded as the resident's needs are identified. The care plan identifies the concern, the goal and interventions. b. Care plans are reviewed weekly with the weekly progress note and quarterly during the IDT team meetings. c. Upon any condition changes or order changes, the care plan is updated. d. Updating consists of the revision date and the information updated.During a review of the facility's P&P titled, Care Plan Revision, dated 9/4/2016, the P&P indicated, . In revising of a care plan, staff identify which areas in the president's plan of care require updating to reflect the current situation . The ultimate goal of the care plan is to provide the plan of care for the resident in question . can plans need to be revised when orders have changed. Care plans need to be revised when they no longer are appropriate for the resident. Care plans need to be revised to reflect on the current status of the resident. The nursing care plan can be computerized or in written form and is a representation of clinical judgment. The nursing care plans contain diagnosis, treatments, and reflective practice for the individual resident.During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call.Knowledge and abilities. 5. Organize and direct total nursing service on their respective shift.6. Recognize changes in the condition of each resident and take necessary action.During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts. 10 . Recognize the significant changes in the condition of each resident . follow through with the appropriate action. Document change or condition or residence chart.During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.During a review of the facility's document titled, Job Description, Director of Nursing, dated 12/29/2025, the document indicated . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care .During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . (continued on next page) |

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| Sierra View Homes | 1155 E. Springfield Avenue<br>Reedley, CA 93654 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services were provided to restore or improve normal bladder function and bowel function to the extent possible for one of eight sampled residents (Resident 6), when Resident 6's bowel and bladder training (a behavioral technique used to help individuals regain control over their bladder and bowel function) for incontinence (lack of voluntary control over urination or defecation) was not implemented.This failure had the potential to place Resident 6 at risk for urinary tract infections (UTI -infection of any part of the urinary system), pressure ulcers (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and not maintaining or improving Resident 6's Activities of Daily Living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). Findings:During a concurrent observation and interview on 02/04/2026 at 3:16 p.m. in Resident 6's room, Resident 6 was observed dressed and sitting in a wheelchair next to her bed. Resident 6 stated she had been at the facility for a couple of months for getting sick. Resident 6 stated she wore a brief and had no bowel or bladder training. Resident 6 stated recently her bum hole was very irritated.During a review of Resident 6's AR, dated 2/10/26, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (a condition where brain function is disturbed due to different diseases or toxins [poisons] in the blood), pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), sepsis (a serious condition in which the body responds improperly to an infection), acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood), atrial fibrillation (an irregular heartbeat), UTI, weakness, and 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).During a review of Resident 6's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/26/26, the MDS section C indicated Resident 6 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) 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 6 was cognitively intact.During a review of Resident 6's MDS, dated 1/26/26, the MDS section GG indicated, .toileting hygiene. 04 - Supervision or touching assistance - helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.toilet transfer.04 - Supervision or touching assistance.During a review of Resident 6's MDS, dated 1/26/26, the MDS section H - Bladder and Bowel indicated, .has a trial of a toileting program (e.g., scheduled toileting, prompted voiding, or bladder training) been attempted on admission/entry or reentry or since urinary incontinence was noted in this facility .No.urinary continence.always incontinent.bowel continence.always incontinent.During a review of Resident 6's Bowel and Bladder Program Screener (B&B Screener), dated 1/29/26, the B&B Screener indicated, .voids appropriately without incontinence? .not always, but at least daily.incontinent of stool.1-3[times per week].mentally aware of need to toilet.usually aware of need to toilet.Score 13.Candidate for Schedule toileting [timed voiding].During an interview on 2/9/26 at 12:40 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated if a resident was on a B&B training program, the CNAs would have encouraged the residents to use the bathroom, push fluids, encourage food, check the residents every one to two hours for bowel movement (BM), and will check the residents every two hours to see if they needed to use the bathroom. CNA 1 stated the Director of Staff Development (DSD) did the training for B&B training. CNA<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 1 stated staff would be notified of residents on a B&B training program during report from the previous shift and the nurse will inform CNAs of residents on a B&B training program. CNA 1 stated there were no residents on a B&B training program.During a concurrent interview and record review on 2/9/26 at 4:15 p.m. with the Infection Preventionist (IP), Resident 6's B&B Screener, dated 1/29/26 was reviewed. The B&B screener indicated, .scheduling toilet program recommended. The IP stated Resident 6 was not on a B&B training program and staff had two weeks from the B&B assessment to decide what to do with the resident. The IP stated she was not sure who did the B&B screening, but whoever completed the screening needed to communicate the results to the Interdisciplinary Team (IDT) or the DSD for B&B training. The IP stated B&B training was important as it helped Resident 6 to become more dignified and able to manage less incontinent episodes. The IP stated there was a risk for Resident 6 to obtain skin breakdown, rashes, skin disorders, and discomfort from incontinence. The IP stated Resident 6 should have had a B&B training program initiated.During a concurrent interview and record review on 2/9/26 at 5:00 p.m. with the DSD, Resident 6's B&B Screener, dated 1/29/26 was reviewed. The B&B Screener indicated, .candidate for schedule toileting [timed voiding].score 13. The DSD stated Resident 6 should have had a B&B training program initiated. The DSD stated she gave B&B training during the facility's annual in-services to staff. The DSD stated staff were to toilette B&B training residents at least every two hours when the residents were awake and during rounds at night. The DSD stated CNAs assisted with checking and changing the residents on B&B training. The DSD stated she needed notification from the IDT or from the person who completed the B&B assessment if a resident needed B&B training so she would be able to initiate a care plan and train staff on implementation and documentation of B&B training.During an interview 2/9/26 at 5:15 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 6 was not on a toileting program. LVN 1 stated Resident 6 called the CNA when she needed to use the bathroom to assist Resident 6 to the wheelchair and the bathroom.During a review of the facility's policy and procedure (P&P) titled, Policy and procedure for Bowel and Bladder Management and Training, dated 11/4/2013, the P&P indicated, .training the bladder to empty when full and lesson the symptoms of an overactive bladder [a condition that causes more frequent and urgent urination] or stress incontinence [when stress or pressure on the bladder causes urine to leak] is the ultimate goal for our residents.if the resident could benefit from bowel and bladder re-training and is a good candidate. Staff will document as required.upon determination that a resident can benefit from the bowel and bladder re-training program, the resident is evaluated for one week if positive results are seen with the resident, the evaluation continues for an additional 2 weeks minimal or as long as required for the individual.assessment of the residents' schedule.train staff to utilize the residents' schedule every two hours. Toileting/offering toileting/checking for need of toileting.staff to assist with toileting as needed.call light kept within reach at all times, and answered promptly.During a review of the facility's P&P titled, The Nursing Process (Nursing Assessments), dated 12/20/17, the P&P indicated, .the assessment: a way of collecting and analyzing data about the resident. The initial step in delivering nursing care.the assessment will also include ADL function.which can affect the care provided.both the residents status and the effectiveness of the nursing care plans require frequent evaluation and updating to reflect the current level of care. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet state/federal laws and professional standards of practice for labeling and storage of drugs and biologicals (medical products or agricultural agents derived from living organisms such as humans, animals, or microorganisms) for two of eight sampled residents (Resident 11 and Resident 47) when:1. Resident 11's controlled medication (medications that are highly regulated by the government because of the significant risk of abuse and dependence they pose) record sheet did not indicate the Administration Instructions (specific directions, including dosage form, route (e.g., by mouth), and frequency (e.g., 1-tab daily) for use of the medications.This failure placed Resident 11 at risk of being administered the wrong dosage of the medication at the wrong time and the route. 2. Resident 47 was administered a controlled medication on 1/3/26 and the Controlled Drug Record (CDR) was not signed by the licensed nurse (LN) according to the facility's policy and procedure (P&P) titled, Controlled Drug Accountability.This failure placed Resident 47 at risk for not receiving her medication which could cause adverse effects (unexpected, harmful, or undesirable reaction resulting from a medication, medical treatment, or procedure, ranging from mild to severe or life-threatening). 3. The facility's medication refrigerator containing residents' medications was not monitored to be within the recommended temperature and the Temperature Log (TL) for medication was not completed accurately according to the facility's P&P titled, Refrigerator Temperatures. This failure had the potential for ineffective medications to be administered to residents.4. Medications were destroyed and the Medication Disposition Log (MDL) was not accurately completed by two required witnesses as indicated on the MDL. This failure had the potential for medications to be diverted (illegal transfer or use of prescription medication).5. Loose medications were found in the west wing medication cart, and the medications were not disposed according to the facility's P&P titled, Discarded Medication.This failure had the potential to be a safety hazard to residents if administered.Findings:1. During an observation on 2/4/2026 at 3:35 p.m. in Resident 11's room, Resident 11 was observed dressed, lying in bed, and unable to respond appropriately to questions asked.During a review of Resident 11's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 11 was admitted to the facility from an acute care hospital on 6/22/25 with diagnoses which include . essential hypertension [high blood pressure that has no single, identifiable medical cause], gastroesophageal reflux disease [condition where stomach acid frequently flows back into the tube connecting the mouth and stomach [esophagus]], varicose veins [swollen, twisted, and enlarged veins that usually appear blue or dark purple just under the skin's surface, most commonly in the legs] of unspecified lower extremity with ulcer of unspecified sites, alcoholic cirrhosis of liver with ascites [a severe, advanced stage of liver disease caused by long-term alcohol abuse], venous insufficiency [condition where leg vein valves are damaged or weakened, preventing blood from flowing efficiently back to the heart), anxiety disorder [mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life] .During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/22/25, the MDS section C indicated Resident 11 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 07 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS score indicated Resident 11 had severe<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | cognitive impairment.During a review of Resident 11's Order Summary report (OSR), the OSR indicated Resident 11 had physician orders for Lorazepam (a Schedule IV controlled medication used for short-term treatment of anxiety disorders (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), insomnia (sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early, despite having the opportunity to rest , acute seizures (a sudden, temporary burst of abnormal electrical activity in the brain) Oral Tablet 0.5mg (Milligram- a metric unit of mass equal to one-thousandth of a gram, used for medicine dosages)- Give 1 tablet by mouth at bedtime to assist with anxiety and or sleep, with a start date of 10/31/25.During a concurrent interview and record review on 2/6/26 at 3:05 p.m. in the west wing nursing station, with Licensed Vocational Nurse (LVN) 4, Resident 11's medication packet, dated 12/12/25 and medication record sheet, undated were reviewed. The medication packet indicated administration instructions, but the medication record sheet did not have the administration instructions. LVN 4 stated the controlled medication labeling was incomplete, noting that lorazepam 0.5 mg was documented without direction or instructions. LVN 4 stated proper labeling was relevant to ensure the right dosage was given to the right patient, at the right time, with the right medication. LVN 4 stated what was missing from the label included when the medication was due, how frequently it should be administered, and the dosage was not clearly written. LVN 4 stated that the importance of accurate labeling was to prevent giving the wrong medication to the wrong patient, or the wrong dosage to the right patient. LVN 4 stated the potential outcome of such an error could result in the wrong patient experiencing an allergic reaction (a set of symptoms that happen after you touch, inhale or eat something) or death, while the intended patient does not receive their medication resulting in a double loss.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), the pictures of Resident 11's medication packet, dated 12/12/25 and medication record sheet, undated were reviewed. The DSD stated the medication was not properly documented with indication, noting that the label was handwritten rather than generated from the pharmacy, and therefore lacked the required pharmacy sticker. The DSD stated the indications on the medication record sheet were missing, which was important as proper documentation serves as a way to double check what was being administered and confirms the correct timing of the medication.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), the pictures of Resident 11's medication packet, dated 12/12/25 and medication record sheet, undated were reviewed. The DON stated Resident 11's medications were not properly documented with indications noting that the handwriting was sloppy and illegible and did not constitute a complete order. The DON stated that the implication of such incomplete documentation was a medication error. The DON stated the importance of complete documentation was to prevent medication errors as the label failed to include the time, route, indication, and frequency, making it easy for mistakes to occur. The DON stated that the potential outcome of this deficiency was a medication error.During a review of the facility's P&P titled, Safe administration assistance, dated 5/14/2021, the P&P indicated, . Procedure. General and specific procedures on administration of medication: right person, right medication, right date, right time, right route, and right dose, expiration date. If there is a discrepancy, the medication will not be administered until the physician verifies appropriate instruction .During a review of the facility's &P titled, Medication and treatment administration, dated 5/14/2021, the P&P indicated, . Policy: The complete nursing function of administering drugs entails preparing the individual dose from a dispensed, prepared container, charting the time, dose of medication and actually administering the dose. The licensed nurse is responsible for selecting the correct drug from supply, and knowing how to administer such medication, verifying the identity of the medication, verifying the identity of the resident. In administering medication, medication sheets are used as a check against physicians' orders .2. During a review of Resident 47's AR, dated 2/11/26, the AR indicated Resident 47 was admitted to the facility from an acute care hospital on [DATE] with diagnoses which included . (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | hypokalemia [condition characterized by abnormally low levels of potassium in the blood], pneumonia [an infection that inflames the air sacs (alveoli) in one or both lungs, causing them to fill with fluid or pus], essential primary hypertension [a condition where the force of blood pushing against your artery walls is consistently too high], depression [a common, serious mood disorder characterized by a persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities] .During a review of Resident 47's MDS, dated [DATE], the MDS section C indicated Resident 47 had a BIMS score of 11, which indicated Resident 47 was moderately impaired.During a review of Resident 47's OSR, the OSR indicated Resident 47 had physician orders for Lorazepam Oral tablet 0.5mg- Give 0.5 tablet by mouth at bedtime for anxiety/phobias (feeling of worry or fear about future events) with a start date of 12/14/25.During a review of Resident 47's Medication Administration Record (MAR), the MAR indicated Lorazepam Oral tablet 0.5mg- Give 0.5 tablet by mouth at bedtime for anxiety/phobias and was checked off as administered to Resident 47 on 1/3/26.During a review of Resident 47's CDR,, the CDR indicated the Lorazepam Oral tablet 0.5mg- Give 0.5 tablet by mouth at bedtime for anxiety/phobias and was not signed off by the LN on 1/3/26 at 8:00 p.m.During a concurrent interview and record review on 2/6/26 at 11:03 a.m. in the west wing nursing station, with LVN 4, Resident 47's CDR, dated 1/3/26, and Resident 47's MAR, dated 1/3/26 were reviewed. were reviewed. The CDR indicated there was a blank space that required a LN's signature. The MAR indicated the medication Lorazepam 0.5mg was administered to Resident 47 on 1/3/26. LVN 4 stated the controlled medication was administered and there was one missing signature on the CDR on 1/3/26 for Resident 47. LVN 4 stated the process for Controlled Drug Accountability required that at shift change, oncoming and outgoing LNs performed a medication count to ensure accuracy, both nurses signed to verify that the count was completed and accurate and when controlled medications were given, the LN must sign to confirm administration. LVN 4 stated this was important because these are controlled substances and if the count was off there could be suspicion of diversion and it was essential to ensure residents were receiving the medications they were ordered to take. LVN 4 stated the potential outcome was if a pain medication was missed, the resident could be in pain and if lorazepam was missed, then the resident could become restless.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, the pictures of Resident 47's CDR, dated 1/3/26 and MAR, dated 1/3/26 were reviewed. The DSD stated the situation was a controlled medication concern, noting that nurses were required to count the medication, verify the account and sign the record sheet when the medication was administered to residents. The DSD stated this was important because if the count was not accurate or the record sheet was not signed, there was no way to account for what happened to the medication. The DSD stated the potential outcome was that Resident 47 may not receive the medication she was supposed to get, which could leave her experiencing anxiety.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, the pictures of Resident 47's dated 1/3/26 and MAR, dated 1/3/26 were reviewed. The DON stated a controlled medication concern was identified for Resident 47, noting that a signature for lorazepam administration was missing. The DON stated the process of controlled drug accountability required the LNs to sign for any medications administered to the residents. The DON stated this was important to keep the medication count accurate and to ensure residents received their medication as scheduled. The DON stated the potential outcome of this practice was that the count could be off and the residents could experience anxiety as a result of not receiving their medication.During a review of the facility's P&P titled, Controlled Drug Record, dated 5/14/2021, the P&P indicated, Policy- It shall be the policy of [named company] skilled unit to be accountable for controlled medication and antibiotic medications each shift Accounting process for controlled drugs: when controlled drugs are delivered a controlled / antibiotic drug log record is made for each drug usually the pharmacy will provide these, but if not, the nurse is to make one. Procedure for providing controlled medication: the number of pills is listed on the record, and each time a medication is given, it is signed for by the licensed nurse. The nurse is to pour the pill, sign the pill out of the controlled/ antibiotic drug log<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | record, give the medication to the resident and then document and sign the medication record.3. During a concurrent observation, interview, and record review on 2/6/26 at 11:03 a.m. in the west wing nursing station, with LVN 4, a medication refrigerator had medications stored in it and the refrigerator temperature was 34 Fahrenheit ( F- a scale for measuring temperature). There was a temperature guide displayed on the side of the west wing refrigerator at the nursing station. The facility's temperature guide was reviewed with LVN 4. The temperature guide indicated . At 40 F- The Us Food and Drug Administration (FDA) says the recommended refrigerator temperature is below 40 F. Between 35 F and 38 F- The ideal refrigerator temperature is between 35 F and 38 F, below the safety threshold outlined by the FDA and above freezing. LVN 4 stated and validated the refrigerator temperature was at 34 F.During a concurrent interview and record review on 2/6/26 at 11:10 a.m. with LVN 4, the facility's TL, dated November 2025, December 2025, and January 2026 were reviewed. The TL indicated in the month of January 2026, the log was not completed 14 out of 31 times on the morning (AM) shift and the temperature was at 36 F and below 16 times out of 17 recorded entries on the AM shift, the log was not completed 10 out of 31 times on the afternoon (PM) shift and the temperature was at 36 F and below 20 times out of 21 recorded entry on the PM shift, and the log was not completed 1 out of 31 times on the night (NOC) shift and the temperature was at 36 F and below 25 times out of 30 recorded entries on the NOC shift. The TL indicated in the month of December 2025, the log was not completed 7 out of 31 times on the AM shift and the temperature was at 36 F and below 24 times out of 24 recorded entries on the AM shift, the log was not completed 5 out of 31 times on the PM shift and the temperature was at 36 F and below 25 time out of 26 recorded entries on the PM shift, and the log was not completed 2 out of 31 times on the NOC shift and the temperature was at 36 F and below 29 times out of 29 recorded entries on the NOC shift. The TL indicated in the month of November 2025, the log was not completed 10 out of 31 times on the AM shift and the temperature was at 36 F and below 21 times out of 21 recorded entries on the AM shift, the log was not completed 2 out of 30 times on the PM shift and the temperature was at 36 F and below 28 time out of 28 recorded entries on the PM shift, and the log was completed on the NOC shift and the temperature was at 36 F and below 30 times out of 30 recorded entries on the NOC shift. LVN 4 stated temperatures should be checked every day. LVN 4 stated checking the refrigerator was important to ensure the temperature of the refrigerator was in the ideal range as failure to check could lead to medication damage. LVN 4 stated the potential outcome of improper storage of medication was that residents could get sick, the chemical composition of medications could change, and residents may not receive the intended effects from their medications. LVN 4 stated there was missing documentation on the temperature logs. LVN 4 stated the expectation was that the temperature log should have been completed.During an observation on 2/9/26 at 3:18 p.m. in the medication room, the medication refrigerator temperature was 26 F. The refrigerator was observed to contain various residents medications, some of which were Insulins (vital hormone produced by the pancreas that acts as a key, allowing sugar (glucose) from food to enter cells to be used for energy e.g insulin glargine), a box of influenza vaccine (a safe, yearly injection that helps the immune system fight the flu virus), lorazepam oral concentrate 30 mL (milliliter- unit of measure), a box of 5TU/ 0.1 mL tuberculin (sterile liquid used in a skin test to see if a person has been infected with tuberculosis) vial. The insulin glargine indicated, .store unused insulin glargine in a refrigerator 36 F-46 F .Do not freeze. Discard insulin glargine if it has been frozen, the Influenza vaccine indicated store between . (36 F-46 F). Do not freeze. The Lorazepam indicated, .store at cold temperature. Refrigerate . (36 F-46 F). The tuberculin indicated .store between . 36 F-46 F. Do not freeze.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, the pictures of the thermometer (an instrument used to measure how hot or cold something is[temperature]) in the medication room refrigerator and the temperature logs for the refrigerator, undated were reviewed. The DSD stated the policy required temperature checks once a day, with the facility standard being twice a day, and that the blanks in the logs should have been filled in. The DSD stated this was important because if<br>(continued on next page) |

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| | 056279 | A. Building<br>B. Wing | 02/11/2026 |

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| Sierra View Homes | 1155 E. Springfield Avenue<br>Reedley, CA 93654 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medications were not stored at the correct temperature, they could be harmful. The DSD stated the potential outcome was an adverse consequence resulting from administering medications that were not stored at the proper temperature. The DSD stated and validated the temperature of the refrigerator was 26 F which fell within the freezing zone as indicated by the reviewed guide. The DSD stated upon reviewing the manufacturer's guide, Tuberculin should be stored between 36 - 46 F and should not be frozen, lorazepam should be stored between 36 - 46 F and influenza vaccine should be stopped between 36 - 46 F and should not be frozen. The DSD stated the expectation was that the refrigerator should be monitored twice a day, and if found out of range, medications should be discarded, the refrigerators should be repaired, and the temperatures should be confirmed to be within the correct range before replacing with new medications. The DSD stated that this was important because improper storage could cause harm to residents and the potential outcome was an adverse health consequence.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, the pictures of the thermometer in the medication room refrigerator and the temperature logs for the refrigerator, undated were reviewed. The DON stated the log was found to be incomplete, and the policy required the night shift nurse to monitor the temperatures. The DON stated this was important to maintain the proper temperature of the refrigerators and that the potential outcome of noncompliance included spoiled or frozen items. The DON stated upon reviewing the medication refrigerator temperature it was found to be too low at 25 F and that the expectation was that the refrigerator should have been maintained between 36 - 46 F. The DON stated this was important to keep medications accurate and safe, and the potential outcome of improper temperature included illness and adverse effects from medication use.During a review of facility's document titled, The right temperature for your refrigerator and freezer, dated 6/26/25, the document indicated, Refrigerator temperature guide- Above 40 - Any temperature above 40 F may allow bacteria to multiply rapidly. At 40 , the U.S. Food and Drug Administration says the recommended temperature is below 40 F. Between 35 and 38 - the ideal refrigerator temperature is between 35 F and 38 F, below the safety threshold outlined by the FDA and above freezing. It's not uncommon for refrigerators to be a few degrees off the mark you set, so err on the side of too cold to avoid food spoiling more quickly or potential food safety issues. At 32 - At 32 F and below, the food in your refrigerator will start to freeze. Keep your refrigerator temperature above 32 F to avoid this, and if you want anything frozen, put it in the freezer which should be kept below 0 F.During a review of the facility's P&P titled, Refrigerator temperatures, dated 9/29/2009, the P&P indicated, . Purpose: to ensure that the temperatures of the refrigerator in the skilled nursing department are maintained between 36- 41 at all times. Policy: the night shift chart nurse will check and document the temperature of the refrigerator located in the medication room and at the nurses station on a nightly basis to ensure temperatures are between 36-41 degrees at all times. If there is a malfunction and the temperature rises above 41 for more than 1/2 hour, medications will be assessed and destroyed and replaced as needed.During a review of the facility's P&P titled, Storage of medication and treatment supplies, dated 5/14/2021, the P&P indicated, . Policy: [Named company] Policy for medication and treatment supplies storage is to maintain medication and supplies in adequate storage areas in accordance to health and safety regulations. Storage of unused medications and/ or treatment supplies shall be . adequate temperature, adequate humidity 4. During a concurrent interview and record review on 2/6/26 at 11:10 a.m. with LVN 4, the facility's MDL, dated October 2025, November 2025, and December 2025 were reviewed. The MDL indicated in the month of October 2025, the log was not signed by a second witness 33 out of 49 times which involved 41 out of 58 medications destroyed not signed by a second witness. The MDL indicated in the month of November 2025, the log was not signed by a second witness 132 out of 135 times and was not signed by two witnesses 1 out of 1 time which involved 277 out of 285 medications destroyed not signed by a second witness and 1 out of 1 medication destroyed not signed by two witnesses. The MDL indicated in the month of December 2025, the log was not signed by a second witness 24 out of 40 times which involved 30 out of 47 medications destroyed not<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | signed by a second witness. LVN 4 stated the MDL required both a nurse and a witness to sign when medications were destroyed, however multiple witness signatures were found to be missing. LVN 4 stated the process for medication destruction was required whenever LNs had time or at least once a week, one of the LNs would retrieve the medication destruction bin, destroy the medications, document and sign, then a second nurse will verify that the medications have been destroyed and signed the document as a witness, with both nurses ensuring the medications were placed in the incineration box (is an enclosed, furnace-like container designed to safely burn waste materials at very high temperatures). LVN 4 stated the process was followed part of the time and was not followed part of the time. LVN 4 stated it was important to ensure that medications were destroyed as they are supposed to be, and that the potential outcome of noncompliance was that the medications could be diverted.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, the pictures of the MDL were reviewed. The DSD stated when medications were discontinued, they are to be discarded with a witness by another LN during incineration, and the details of the discarded medications were to be entered and signed by both LNs. The DSD stated this was important as it served as verification that the destruction was actually completed and that no one was taking the medications for personal use. The DSD stated the potential outcome of noncompliance was that individuals could be taking the medications home or sell them.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, the pictures of the MDL were reviewed. The DON stated the expectation was that two LNs should be present for discarding and documenting when medications are destroyed. The DON stated this was important because it was the proper way to ensure medications were safely destroyed. The DON stated the potential outcome of noncompliance was medications could get into the wrong hands.During a review of the facility's P&P titled, Disposal of Medications, dated 5/14/2021, the P&P indicated, . Policy: Discontinued medications and/ or medications left in the nursing care center after a residence discharge, which do not qualify for return to the pharmacy, are identified and removed from current medication supply in a timely manner for disposition Procedures the director of nursing and the consultant pharmacist will monitor for compliance with federal and state laws and regulations in the handling of medications .5. During a concurrent observation and interview on 2/6/2026 at 3:05 p.m. in the west wing hallway with LVN 4, three loose medications were found in different places in the medication cart. LVN 4 was unable to identify the medications. LVN 4 stated the process required the medication cart to be checked at all times to ensure there were no loose medications present. LVN 4 stated this was important because medications left lying around could be dangerous.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the DSD, the pictures of the loose medications found in the medication cart were reviewed. The DSD stated the loose medications found in the medication cart may indicate that residents were not receiving their medications. The DSD stated the expectation was that any medication not given should be documented as not administered and if the medication needed to be discarded, it should go through the proper disposal process with a witness present. The DSD stated this was important because if residents do not receive their medications, it could cause health problems.During a concurrent interview and record review on 2/10/26 at 2:35 p.m. with the Infection Preventionist (IP), the pictures of the loose medications found in the medication cart were reviewed. The IP stated the expectation was that the medication should have been removed from the medication cart, the pharmacy should have been contacted, and the replacement medication should have been ordered. The IP stated this was important because residents may not receive the medications prescribed to them. The IP stated the potential outcome was that if the resident missed the medication, the intended effects of the medication would not be active in the resident.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the DON, the pictures of the loose medications found in the medication cart were reviewed. The DON stated the loose medications found in the medication cart were not disposed of properly. The DON stated this was important because administering those medications could result in a medication error, and proper disposal was (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | necessary to prevent that from occurring.During a review of the facility's P&P titled, Discarded Medication, revision dated 5/14/2021, the P&P indicated, . Policy: As medications are being passed, there are times that medications need to be discarded due to resident refusal or dropped pills for example. Loose medications are a safety hazard for residents. The facility has a responsibility to maintain a safe environment for residents. Through this process the facility will maintain the safety of the residents. Procedure: A labeled container will be kept in the Med cart for the purpose of collecting discarded medications, excluding narcotic medications. As incidents happen of pills that are not administered to the resident for various reasons, the pills will be placed in the labeled container for later removal to the grey discard box in the Med room. Every Monday night, the night shift nurse is responsible to place the container in the grey discard box in the Med room. If the container becomes too full during the week, the nurse that notes it being too full is responsible to deposit the medications in the designated grey box in the Med room for the DON to appropriately discard.During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated, . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. 3 .gives or supervises giving of all prescribed treatments. 4. notes and transcribe physicians' orders with their appropriate flow through.Knowledge and abilities. 3. Give medication as prescribed with good basic knowledge of side effects of these.5. Organize and direct total nursing service on their respective shift.During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts. 3 .gives medication as prescribed .6. Gives and supervises giving of all prescribed treatments. 7. notes and transcribe physicians' orders with their appropriate flow through.Knowledge and abilities. Give medication as prescribed with good basic knowledge of side effects of these.During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated, . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.During a review of the facility's document titled, Job Description, Director of Nursing, dated 12/29/2025, the document indicated, . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care . |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' call light was within reach for three of eight sampled residents (Resident 9, 11, and 55), when:1. Resident 9's call light was on the floor and not within his reach.2. Resident 11 and Resident 55's call lights were on their dressers and not within their reach. These failures had the potential to cause harm to Resident 9, Resident 11, and Resident 55 when these residents were not able to call for assistance with the use of their call lights in the event of an emergency.Findings:1. During an observation on 2/4/2026 at 3:35 p.m. in Resident 9's room, Resident 9 was observed dressed and lying in bed with eyes closed. Resident 9's call light was observed to be on the floor at the head of the bed and was not within Resident 9's reach.During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/11/26, the AR indicated Resident 9 was admitted to the facility from an assisted living /board and care/group home on [DATE] with diagnoses which include . Acute and chronic respiratory failure with hypoxia (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), epileptic seizures (a sudden, temporary surge of uncontrolled electrical activity in the brain that disrupts normal function), bipolar disorder (chronic mental health condition characterized by intense, extreme shifts in mood, energy, and activity levels, ranging from high-energy manic episodes to low-energy depressive episodes), heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), .During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/8/26, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 03 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS scores indicated Resident 9 had severe cognitive impairment.During a review of Resident 9's MDS assessment section GG Functional Abilities, dated 2/8/26, the MDS indicated Resident 9's functional abilities were coded 02. Resident 9 was code 02 (substantial/ maximal assistance: helper does more than half the effort) for toilet hygiene, shower/bath self, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, roll left and right, sit to lying, lying-to-sitting on side of bed, sit to stand, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. The functional abilities code indicated Resident 9 needed substantial/ maximal assistance in 13 abilities.2. During an observation on 2/4/2026 at 3:35 p.m. in Resident 11's room, Resident 11 was observed dressed, lying in bed, and unable to respond appropriately to questions asked. Resident 11's call light was observed to be placed on his dresser and was not within Resident 11's reach.During a review of Resident 11's AR, dated 2/11/26, the AR indicated Resident 11 was admitted to the facility from an acute care hospital on 6/22/25 with diagnoses which include . essential hypertension (high blood pressure that has no single, identifiable medical cause), gastroesophageal reflux disease (condition where stomach acid frequently flows back into the tube connecting the mouth and stomach [esophagus]), varicose veins (swollen, twisted, and enlarged veins that usually appear blue or dark purple just under the skin's surface, most commonly in the legs) of unspecified lower extremity with ulcer (an open, painful sore on the skin that occurs when surface tissue breaks down) of unspecified sites, alcoholic cirrhosis of liver with ascites (a severe, advanced stage of liver disease caused by long-term alcohol abuse), venous insufficiency (condition where leg vein valves are damaged or weakened, preventing blood (continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | from flowing efficiently back to the heart), anxiety disorder (mental health conditions characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life), .During a review of Resident 11's MDS, dated [DATE], the MDS section C indicated Resident 11 had a BIMS score of 07, which indicated Resident 11 had severe cognitive impairment.During a review of Resident 11's MDS assessment section GG Functional Abilities, dated 12/22/25, the MDS indicated Resident 11's functional abilities were coded between 01, 02 and 88. Resident 11 was code 01 (dependent: helper does all the effort; resident does none of the effort to complete self-care) for shower/bath self. Resident 11 was code 02 (substantial/ maximal assistance: helper does more than half the effort) for oral hygiene, toilet hygiene, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, lying-to-sitting on side of bed, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident 11 was code 88 (not attempted due to medical condition or safety concerns) for sit to stand. The functional abilities code indicated Resident 11 needed substantial/ maximal assistance in 10 abilities, was dependent on facility staff in 1 ability and 1 ability was not attempted due to Resident 11's medical condition or safety concerns.During a review of Resident 11's MDS, assessment, dated 12/22/25, the MDS section H indicated Resident 11's Bladder and Bowel function included Resident 11 was occasionally (less than 7 episodes of incontinence) incontinent (meaning the inability to control when you urinate or have a bowel movement) for urinary continence. Resident 11 was frequently incontinent (2 or more episodes of continence bowel movement) for bowel continence.During an observation on 2/4/2026 at 3:35 p.m. in Resident 55's room, Resident 55 was observed dressed and sitting in bed. Resident 55's call-light was observed to be placed on his dresser and was not within Resident 55's reach. During a review of Resident 55's AR, dated 2/11/26, the AR indicated Resident 55 was admitted to the facility from an acute care hospital on 4/18/25 with diagnoses which include . Senile degeneration of brain (the progressive, irreversible breakdown and death of brain cells [neurons] and their connections), hypothyroidism (condition where the butterfly-shaped thyroid gland in the neck does not produce enough thyroid hormones), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), major depressive disorder (a serious, common medical illness characterized by persistent, intense feelings of sadness, low mood, or loss of interest in activities), anxiety disorder, essential hypertension, acute respiratory failure with hypoxia (condition where body tissues and cells do not receive enough oxygen to function properly ), .During a review of Resident 55's MDS, dated [DATE], the MDS section C indicated Resident 55 had a BIMS score of 00, which indicated Resident 55 had severe cognitive impairment.During a review of Resident 55's MDS assessment section GG Functional Abilities, dated 1/1/26, the MDS indicated Resident 55's functional abilities were coded between 02 and 03. Resident 55 was code 01 (partial/moderate assistance: helper does less than half the effort) for upper body dressing, lower body dressing and tub/shower transfer. Resident 55 was code 02 (substantial/ maximal assistance: helper does more than half the effort) for toilet hygiene, shower/bathe self, putting on/taking off footwear, and personal hygiene. The functional abilities code indicated Resident 55 needed partial/moderate assistance in 3 abilities, and substantial/ maximal assistance in 4 abilities.During a concurrent observation and interview on 2/4/26 at 3:38 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 checked for Resident 9, Resident 11 and Resident 55's call light. CNA 4 found Resident 9's call light on the floor. CNA 4 found Resident 11 and Resident 55's call lights on their respective dressers. CNA 4 stated Resident 11's call light was found hanging over the dresser instead of being placed within the resident's reach. CNA 4 stated the call light should be positioned next to Resident 11 at all times so he could use it when needed. CNA 4 stated it was important in the event Resident 11 needed to use the restroom and required assistance or experienced a fall. CNA 4 stated without proper placement, Resident 11 could experience an emergency and be unable to call for help. CNA 4 stated Resident 9's Call light was found on the floor behind Resident 9's bed. CNA 4 stated the reason for its placement there was unknown. CNA 4 stated Resident 9 was alert, incontinent, and required assistance with transferring and personal care. CNA 4 stated without<br>(continued on next page) |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | access to the call light, Resident 9 would be unable to call for help, thus preventing facility staff from responding to Resident 9's needs in a timely manner. CNA 4 stated Resident 55's call light was found on his dresser rather than within reach. CNA 4 stated the reason for its placement on the dresser was unknown. CNA 4 stated Resident 55 was ambulatory and able to use the bathroom independently, however the call light should have remained within reach at all times in the event of an emergency or if assistance was needed. CNA 4 stated without proper placement of the call light, Resident 55 could attempt to get out of bed unassisted and fall, remained soiled for an extended period of time, or developed pressure sores or skin rashes as a result of delayed care.During a concurrent interview and record review on 2/4/26 at 3:57 p.m. with Registered Nurse (RN) 1, pictures of call lights in Resident 9, Resident 11, and Resident 55's room were reviewed. RN 1 stated and validated that the call light for Resident 11 was found on the dresser, the call light for Resident 9 was found on the floor, and the call light for Resident 55 was found on the dresser. RN 1 stated facility staff needed to be more diligent regarding the placement of call lights, and that call lights should always be kept at the bedside within the residents' reach. RN 1 stated it was important so that facility staff could respond promptly if a resident needed assistance, whether for something as simple as pain management or a more serious emergency. RN 1 stated that the potential outcome of improper call light placement could be fatal, as residents would be unable to reach facility staff when they needed help.During a concurrent interview and record review on 2/9/26 at 4:29 p.m. with the Director of Staff Development (DSD), pictures of call lights in Resident 9, Resident 11, and Resident 55's room were reviewed. The DSD stated call lights should always be within reach of the residents while in bed. The DSD stated it was important in order to prevent falls and to ensure that residents were able to get assistance promptly when needed. The DSD stated the potential outcome of improper call light placement included injuries or other emergencies going unattended.During a concurrent interview and record review on 2/10/26 at 3:15 p.m. with the Director of Nursing (DON), pictures of call lights in Resident 9, Resident 11, and Resident 55's room were reviewed. The DON stated call lights should always be within reach of the residents so that they were able to use them as needed. The DON stated it was important for the overall safety of the residents. The DON stated the potential outcome of improper call light placement included injuries.During a review of the facility's document titled, Job Description, Certified Nurse Assistant (CNA), dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A certified nurse assistant is responsible for the direct care of the group of residents assigned, and provides the activities of daily living care (ADL), including (ADL) documentation, and psychosocial services [relating to the interrelation of social factors and individual thought and behavior].2. To assist also the vice presidents with physical needs such as . Feeding, oral hygiene, .or any other physical need. 8. To encourage the resident to function at his/ her maximum level of ability at all times.During a review of the facility's document titled, Job Description, Registered Nurse, dated 7/12/2023, the document indicated, . Duties and Responsibilities: 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call.5. Organize and direct total nursing service on their respective shift.During a review of the facility's document titled, Job Description, Day Charge Nurse, Afternoon Charge Nurse, Night Charge Nurse, dated 7/12/2016, the document indicated, . Duties and Responsibilities: 1. A licensed professional nurse is responsible for the direct and indirect care of the residents. 2.is responsible for the nursing and nursing home . Provide such service under the direct supervision of the medical doctor and administrator on call. Take and give reports at the beginning and end of shifts.During a review of the facility's document titled, Job Description, Director of Staff Development and Education, dated 7/30/2022, the document indicated, . Duties and Responsibilities: Responsible for the planning, implementation, direction, and evaluation of all facility educational programs . 3 ongoing in-service education. The DSD works in direct conjunction with the director of nursing and all other department heads and is responsible for the education of all facility employees.15. train staff for proper competency or special needs resident.During a review of the facility's document titled, Job (continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056279 | A. Building<br>B. Wing | 02/11/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sierra View Homes | 1155 E. Springfield Avenue<br>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 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Description, Director of Nursing, dated 12/29/2025, the document indicated, . Duties and Responsibilities: 1. Reviews and establishes nursing policies practices and procedures. 2. interprets and administers general policies of [named company]. 3. supervises planning, organization and coordination and directing all nursing services. 4. responsible for effective patient care .During a review of the facility's policy and procedure (P&P) titled, Physical Environment Call Bell System, dated 8/8/2022, indicated, Policy Statement- [named company] maintains adequately equipped communication system to allow residents to call for staff assistance. Requirements: Call light is a remote residents use to call for assistance. Procedure: .Call system available at every resident bedside, restroom, shower area. Call light remotes within resident reach at all times, when in bed.During a review of the facility's P&P titled, Resident Rights, revision dated 7/9/2025, the P&P indicated, . Policy: The facility shall uphold and protect the rights of all residents without discrimination, consistent with federal and state regulations. Resident Rights Include but Are Not Limited To: I. Dignity and Respect. Be treated with dignity, respect and consideration.During a review of National Library of Medicine.org, Professional Reference titled, Use of Notification and Communication Technology (Call Light Systems) in Nursing Homes: Observational Study, dated 3/27/20, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC7148550/ ) the reference indicated, .Among the technologies used in nursing homes is the call light system, which plays a key role in communication. The call light system is critical for interactions between the nursing home staff and their residents. Research conducted in other health care settings has reported that nurse call systems significantly influence overall resident satisfaction in the delivery of their health care by creating a communication link between residents and nursing home staff. Nurse call light systems also help to ensure the safety of patients. a lifeline for patients because it is linked with patients' needs and alerts the staff to the situations in which patients may ask for help. Malfunctions of the nurse call light system can cause negative medical outcomes, . a relationship exists between the time it takes to respond to a call light system and adverse events such as falls. Certified nurse assistants (CNAs) contribute to more than 80% of direct care to residents. they must also respond to different types of alarms such as bed exit, chair exit, and clip alarms, as they are ultimately responsible in cases of adverse events. |