

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 West Lacey Blvd Hanford, CA 93230	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to prepare and distribute food in accordance with professional food service when: 1. The food preparation sink was not equipped with a required air gap (a space that helped keep dirty water from getting into clean water). Which had the potential to allow backflow (dirty water flowing backward into clean water) and contaminate (harmful germs or other unsafe substances were present) food, food contact surfaces and equipment. This failure had the potential to expose all 87 residents residing in the facility to contaminated food, food contact surfaces, and an increased risk of foodborne illness. 2. The facility did not follow the required manual ware washing process by removing a clear plastic food storage and a metal measuring cup from the sanitizer (a chemical solution used to reduce harmful germs on food-contact surfaces to a safe level) before the required one-minute contact time, resulting in the items not being sanitized (harmful germs were reduced to a safe level) prior to air drying. This failure had the potential to expose all 87 residents residing in the facility to contaminated (harmful germs or other unsafe substances were present) food-contact equipment and an increased risk of foodborne illness (an illness caused by eating food contaminated with harmful germs or other unsafe substances). Findings: During an observation on 7/15/26 at 8:54 a.m. the food preparation sink was observed with a colander containing food positioned inside the sink basin. Observation of the plumbing underneath the sink revealed the sink drainpipe extended directly into the drain receptor below without a visible air gap between the end of the drainpipe and the drain receptor. During a concurrent observation and interview on 7/15/26 at 9:28 a.m. with Kitchen Staff (KS) 1, KS 1 used the food preparation sink to wash lettuce for lunch meal. KS 1 confirmed the sink was the designated food preparation sink. KS 1 stated an air gap would help prevent backflow so that, if the sink became backed up, contaminated water would not enter the sink and contaminate food. KS1 further stated I don't think this sink has an air gap. During a concurrent observation and interview on 7/15/26 at 4:28 p.m. with the Maintenance Director (MD) and the Registered Dietitian (RD), the MD confirmed the food preparation sink was not equipped with an air gap. The D stated he had worked at the facility for sixteen years and had not been aware of the requirement for an air gap. The RD stated an air gap helped prevent backflow and contamination of food and confirmed food preparation sinks were required to be equipped with an air gap in accordance with the Food Code. During a review of professional reference titled, FDA Food Code 2022, section 5-402.11 Backflow Prevention, (A) A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (B) Equipment and fixtures used for food preparation or utensil washing must be installed with an air gap or air brake as required to prevent backflow of sewage into the equipment. During a review of the facilities policy and procedure (P&P) titled Accident Prevention-Safety Precautions, dated 2023, the P&P indicated, an airgap is the most reliable backflow prevention device. all food (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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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preparation sinks and other equipment that discharge liquid waste or condensate shall be drained through an air gap into an open floor sink. an air gap between the water supply inlet (drain pipe) and the flood level rim of the plumbing fixture (floor sink drain), equipment or non-food equipment shall be the diameter of the water supply inlet and may not be less than one inch. 2. During an interview on 7/15/26 at 8:45 a.m. with KS 1, KS 1 stated the dishwasher heater had been inoperable since Monday. KS 1 stated the manual ware washing process required washing items in hot soapy water in the first compartment of the three-compartment sink, rinsing items in clean water in the second compartment, and submerging items in sanitizer in the third compartment for one minute before allowing the items to air dry. KS 1 stated sanitizer concentrations were required to remain between 200-400 parts per million (ppm) a way to measure how much sanitizer was mixed into the water) and were verified using sanitizer test strips prior to use. KS 1 stated if the sanitizer concentration measured less than 200ppm, the Certified Dietary Manager (CDM) would be notified and EcoLab would be contacted. KS 1 further stated the sanitizer, and detergent solutions were premixed by EcoLab and dietary staff did not prepare the sanitizer or detergent mixture. During an interview on 7/15/26 at 9:35 p.m. with the CDM, the CDM stated the dishwasher became inoperable on Monday after dietary staff reported it was not reaching the required wash water temperature. The CDM stated maintenance evaluated the dishwasher and determined the dishwasher heater was not functioning. The CDM stated dietary staff were instructed to discontinue use of the dishwasher and utilize the three-compartment sink for manual ware washing until the dishwasher heater was repaired. The CDM further stated the facility was awaiting a replacement part for the dishwasher heater and had been informed the repair was expected to be completed that day. During a concurrent observation and interview on 7/15/26 at 2:56 p.m. with KS 2, KS 2 manually washed a clear plastic food storage bin and a metal measuring cup in the first compartment of the three-compartment sink, rinsed the items in the second compartment and submerged the items in the sanitizer solution in the third compartment. KS 2 immediately removed the clear plastic food storage bin and the metal measuring cup from the sanitizer solution and placed items in the drying rack without allowing the required one-minute sanitizer contact time. During the interview, KS 2 stated manual ware washing process required wash water maintained at least 100 degrees Fahrenheit (a scale used to measure temperature) in the first compartment, rinsing in the second compartment and submerging items in the sanitizer solution in the third compartment for one minute before allowing the items to air dry. KS 2 stated, that is not the process I did for those dishes. I did not leave them in the sanitizer for one minute. KS 2 stated leaving the items in the sanitizer for one minute was important to kill germs. KS 2 immediately rewashed the clear plastic food storage bin and metal measuring cup and demonstrated the correct manual ware washing process. During an interview on 7/15/26 at 3:39 p.m. with the CDM and the RD, the CDM stated the manual ware washing process required hot soapy water in the first compartment of the three-compartment sink, a clean water rinse in the second compartment and sanitizer in the third compartment followed by air drying. The CDM stated items were required to remain submerged in the sanitizer solution for at least one minute before being removed to air dry and that the three-compartment sink process was required to be completed in the correct order to ensure items were properly sanitized and prevent cross-contamination. The CDM stated kitchen staff were reeducated on the proper manual ware washing process on Monday. The CDM further stated KS 2 washed the clear plastic food storage bin and metal measuring cup incorrectly by removing the items from the sanitizer solution before the required one-minute contact time. The RD confirmed the manual ware washing process described by the CDM and stated the process was important to ensure food-contact items were properly sanitized and to prevent cross-contamination. During a review of the facilities policy and procedure (P&P) titled (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Sanitization, dated November 2022, the P&P indicated, manual washing ad sanitizing is a three-step process for washing, rinsing and sanitizing: a. scrape food particles and wash using hot water and detergent; b. rinse with hot water to remove soap residue; and c. sanitize with hot water or chemical sanitizing solution. Chemical sanitizing solutions are used according to manufacturer's instructions.During a review of the facilities job description titled Dietary Supervisor, dated February 2024, the job description indicated, directs and supervises all dietary functions and personnel.hires, orients, trains, disciplines and when appropriate, terminates dietary employees.assures that.handling of food and supplies complies with current state and federal guidelines.maintain kitchen and food storage area in a safe, orderly, clean and sanitary manner.ensures continued compliance with all federal, state and local regulations.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that four out of eight sampled residents (Resident 1, 5, 8, and 57) were free from unnecessary psychotropic (drugs that affect brain activities associated with mental processes and behaviors) medications, when.1. Resident 1 was administered aripiprazole and risperidone, two atypical antipsychotics (medications used to treat mental health conditions that makes it hard to tell what is real and what is not) concurrently, leading to duplicate drug therapy, the facility did not ensure adequate monitoring of behaviors and side effects related to use of Resident 1's 3 psychotropic medications, and no Gradual Dose Reductions (GDR- tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was attempted for Resident 1's antipsychotic medications. 2. Resident 5 was administered risperidone(atypical antipsychotic) and alprazolam (antianxiety medication) and no non-pharmacological interventions (NPI- an activity used to manage mental health symptoms or behaviors without using medications) were attempted, the facility did not ensure adequate monitoring for behavior and side effects related to use of risperidone, venlafaxine, and lorazepam and no GDR were attempted for the use of risperidone, venlafaxine, and lorazepam. These failures had the potential to result in an increased risk of over-sedation (when a medication slows the brain and body more than intended), extrapyramidal symptoms (involuntary muscle movements), and potentially fatal drug-to-drug interactions.3. Inappropriate diagnosis or indication of Amitriptyline medication (used to treat depression) order. 4. No nonpharmacological intervention implemented for Resident 52's use of sertraline (used to treat depression).These failures placed Resident 8 and Resident 57 at risk for experiencing adverse effects from receiving medications without proper monitoring. 1. During a review of Resident 1'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 7/16/26, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (when the body does not make enough or the hormone insulin or can't use it properly), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry), unspecified hyperlipidemia (high cholesterol), major depressive disorder (a mood disorder causing persistent sadness and loss of interest), unspecified dementia (when confusion or mild cognitive impairment can't be clearly diagnosed as a specific type of dementia). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive [ability to think, remember or make decisions] and physical function) Assessment, dated 6/10/26, the MDS indicated Resident 1's Brief Interview for Mental Status (BIMS-an evaluation of attention, orientation and memory recall) score of 05 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had severe cognitive impairment. During a review of Resident 1's MDS section E-Behavior assessment, dated 6/10/26, the MDS section E indicated no hallucinations, no delusions, no physical behavioral symptoms directed (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	towards others, and no verbal behavioral symptoms directed towards others. During a concurrent observation and interview on 7/16/26 at 1:15 p.m. with Resident 1 in her room, Resident 1 was alert and responsive. Resident 1 stated lunch was delicious and stated she was doing just fine. During a review of the facility document titled, Order Details, dated 5/11/23, the document indicated Resident 1 had current orders for Abilify (atypical antipsychotic) oral tablet 10 mg give 1 tablet by mouth two times a day for Schizophrenia M/B auditory hallucinations (experience that feels completely real but happens entirely within the mind without any external triggers) related to hearing the devil speaking to her causing resident distress. The document indicated an order end date of indefinite. During a review of the facility document titled, Order Details, dated 7/27/23, the document indicated Resident 1 had current orders for Risperdal (atypical antipsychotic) oral tablet 2 mg give 1 tablet by mouth one time a day for Schizophrenia manifested by visual hallucinations: seeing the devil causing distress to resident. The document indicated an order end date of indefinite. During a review of the facility document titled, Order Details, dated 3/29/23, the document indicated Resident 1 had current orders for Xanax tablet 0.25 mg give 1 tablet by mouth every 8 hours for anxiety M/B emotional outburst causing resident distress. The document indicated an order end date of indefinite. During an interview on 7/17/26 at 2:33 p.m. with the Director of Nursing (DON), the DON stated Resident 1's psych note evaluation dated 6/9/26 was completed and indicated to continue both atypical antipsychotic medications (Abilify and Risperdal). During an interview on 7/17/26 at 4:31 p.m. with the Consultant Pharmacist (CP), the CP stated normally a resident should not be on two atypical antipsychotics. During a review of the facility document titled, [Resident 1's name], (undated), the document indicated the name of the medications taken by Resident 1 and the total number of behaviors documented by nursing staff per month. The document indicated, .Xanax. [DATE].[DATE].[DATE]. April 0. May 48. June 0.TOTAL 363.Abilify.[DATE].[DATE].[DATE].April 0.May 39.June 0.Total 389.Risperdal.[DATE].[DATE].[DATE].April 0.May 157.June 0.Total 475. During a review of the facility document titled, Care Plan Report, dated 6/19/26, the document indicated, .Focus. [residents name] uses psychotropic medications (Abilify, Risperdal) r/t Behavior management- M/B Auditory hallucinations r/t [related to] Hearing the Devil.Goal.will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date.will reduce the use of psychoactive medication through the review date as indicated. The facility document did not indicate objective measurable goals for the monitoring of behaviors related to psychotropic medications. During an interview on 7/17/26 at 3:52 p.m. with the DON, the DON stated Resident 1's current care (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	GDR, then providers would not know if that was the lowest most effective dose for that resident. During an interview on 7/17/26 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she usually worked on the [NAME] Back Side of the building, worked with Resident 1 regularly and was familiar with that resident. LVN 5 stated Resident 1 had episodes of yelling and talking to herself in her room frequently. LVN 5 stated monitoring for Abilify included auditory hallucinations-hearing devil speaking to her causing distress to resident and monitoring for Risperdal included visual hallucinations-seeing the devil causing distress to resident. LVN 5 stated she differentiated auditory hallucination and visual hallucinations by observing Resident 1's behaviors. LVN 5 stated if Resident 1 was looking around and verbally speaking to herself then LVN 5 would document that as auditory hallucinations. LVN 5 stated If resident was talking to herself and looking in a certain direction LVN 5 would document that as visual hallucinations. During a concurrent interview and record review on 7/17/26 at 2:50 p.m. with the DON, Resident 1's Psych eMAR dated May 2026 was reviewed. The DON stated the total tally marks for behaviors from the previous month were documented on Resident 1's current Psych eMAR. The DON stated the Psych eMAR indicated how nurses were to document auditory hallucination and visual hallucinations as per eMAR orders. The DON stated tally marks for April 2026 (documented on May 2026 Psych eMAR) for episodes of anxiety m/b emotional outbursts causing resident distress (Xanax), episodes of schizophrenia m/b auditory hallucinations r/t hearing the devil speaking to her (Abilify), and episodes of schizophrenia m/b visual hallucinations seeing the devil causing distress (Risperdal) were tallied as 0. Psych eMAR for Feb. 2026 (documented on March 2026 Psych MAR) indicated tally marks 0 for the month of February. The DON stated it was unlikely that tally marks were exactly the same on the psych eMAR for anxiety m/b emotional outbursts causing resident distress (Xanax), episodes of schizophrenia m/b auditory hallucinations r/t hearing the devil speaking to her (Abilify), and episodes of schizophrenia m/b visual hallucinations seeing the devil causing distress (Risperdal) and stated it was not likely the documentation was accurate. The DON stated inaccurate documentation could change how the physician medicated Resident 1 and could affect Resident 1's plan of care. The DON stated if there was continued documentation of high numbers of behaviors, it would keep the providers from attempting to gradually reduce Resident 1's use of psychotropic medications. 2. During a review of Resident 5's AR dated 7/16/26, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, anxiety disorder (hyperlipidemia), major depressive disorder dementia with other behavioral disturbance (memory loss or cognitive decline alongside significant, disruptive psychological or behavioral changes), psychosis (a mental state where a person loses touch with reality). During a review of Resident 5's MDS Assessment, dated 4/11/25, the MDS indicated Resident 5 had a BIMS score of 06 indicating Resident 5 had severe cognitive impairment. During a review of Resident 5's MDS section E-Behavior assessment, dated 4/11/25, the MDS section E indicated no hallucinations, no delusions, no physical behavioral symptoms directed towards others, and no verbal behavioral symptoms directed towards others. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/14/26 at 11:43 a.m. with Resident 5, Resident 5 was in the dining room sitting on the wheelchair (WC) alert and responsive. Resident 5 responded to questions appropriately and stated she had no concerns regarding her care. During a review of the facility document titled, Order Details, dated 5/21/25, the document indicated Resident 5 had current orders for Venlafaxine HCL (antidepressant) oral tablet 100 mg give 1 tablet by mouth one time a day for depression M/B sadness over loss of life roles. The document indicated an order end date of indefinite. During a review of the facility document titled, Order Details, dated 6/24/25, the document indicated Resident 5 had orders at that time for Risperdal (atypical antipsychotic) oral tablet 0.5 mg give 1 tablet by mouth at bedtime for psychosis m/b verbalizing visual hallucination seeing a man with a gun trying to get her that is not present causing resident distress. During a review of the facility document titled, Order Details, dated 3/25/26, the document indicated Resident 5 had current orders for Risperdal (atypical antipsychotic) oral tablet 1 mg give 0.5 mg by mouth one time a day for unspecified psychosis m/b verbalizing visual hallucinations seeing a man with a gun trying to get her that is not present causing resident distress and give 1 mg by mouth at bedtime for unspecified psychosis m/b verbalizing visual hallucinations seeing a man with a gun trying to get her that is not present causing resident distress . The document indicated an order end date of indefinite. During a review of the facility document titled, Order Details, dated 10/21/25, the document indicated Resident 5 had current orders for Lorazepam (anxiety agent) oral tablet 0.5 mg give 1 tablet by mouth one time a day for anxiety. The document indicated an order end date of indefinite. During a review of the facility document titled, *PACS-MEDICATION ADMINISTRATION RECORD, dated July 2026, the document indicated, Lorazepam Oral Tablet 0.5 MG.Give 1 tablet by mouth.for ANXIETY DISORDER.m/b repetitive movement.Risperdal Oral Tablet 1 MG.Give 0.5 mg by mouth.for UNSPECIFIED PSYCHOSIS M/B verbalizing visual hallucination.Risperdal Oral Tablet 1 MG.Give 1 mg by mouth. for UNSPECIFIED PSYCHOSIS M/B verbalizing visual hallucination. During a review of the facility provided document titled, [hospital]dated 6/18/25, the document indicated Resident 5 had a urinalysis (a test that checks the urine for infections, kidney problems, diabetes, and liver disease) on 6/18/25. The document indicated, .UA-Appearance. Cloudy.UA-Bacteria. Many. During a review of the facility provided document titled, [hospital] dated 6/18/25, the document indicated Resident 5 had a urine culture (a laboratory test to check the urine for bacteria, yeast, or other microorganisms) on 6/18/25. The document indicated, .Cipro [antibiotic] 500 mg BID [twice a day] x 3 day. During an interview on 7/17/26 at 3:22 p.m. with the DON, the DON stated she was unable to find documentation regarding non-pharmacological interventions (NPI) for Resident 5 prior to starting Risperdal. The DON stated psychosis alone was not an appropriate diagnosis for the use of Risperdal. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated it was important to be cautious with the use of antipsychotics in dementia residents because there was a black box warning (the strictest safety-related alert the federal government requires for prescription drugs) because there was an increased risk for cardiac (relating to the heart) death in dementia residents who were on antipsychotics. The DON stated Resident 5 had a diagnosis of anxiety manifested by repetitive movement and a diagnosis of dementia. The DON stated nurses would not be able to distinguish between repetitive movement as a manifestation of dementia and repetitive movement due to anxiety. The DON stated fidgeting alone/ repetitive movement would not be a good enough symptom for the use of lorazepam. During an interview on 7/17/26 at 4:10 p.m. with the Physician Assistant (PA), the PA stated psychosis was not an indication for chronic use of Risperdal and NPI's should have been implemented prior to starting Risperdal considering Resident 5 was prescribed antibiotics after a urinalysis during the same time the Risperdal was ordered. PA stated it was normal for a resident with dementia to be fidgeting/ have repetitive movement. PA stated fidgeting/repetitive movement alone was not an indication to prescribe lorazepam. During a review of the facility document titled, Care Plan Report, dated 5/13/26, the document indicated, .Focus. [residents name] uses antipsychotic medication for visual hallucinations.Goal. [resident name] will be/remain free of drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. The facility document did not indicate objective measurable goals for the monitoring of behaviors related to psychotropic medications. During an interview on 7/17/26 at 3:58 p.m. with the DON, the DON stated Resident 5's current care plan did not have objective measurable goals for the use of lorazepam and Risperdal and it was important to have measurable goals for behaviors related psychotropic medications because it gave providers an idea what current goals were and that what was being done for the resident was trending in the right direction. The DON stated the goal was to lower the medication dose and keep behavioral episodes trending down. During an interview on 7/17/26 at 4:18 p.m. with the PA, the PA stated there should be objective measurable goals for Resident 5 and it was important to have less side effects with medications, and that lowering doses of medications minimized the likelihood of side effects. During a review of the facility document titled, IDT PSYCHOTHERAPEUTIC REVIEW, dated 6/23/26, the document indicated, .PSYCHOTHERAPEUTIC REVIEW.4. Minimal Effective Dosing-Date(s) dose reduction attempted, result of attempted reduction. September 2025: Leave as is, meds seem to be helping.June 2025: Continue Venlafaxine 100 mg daily. The DON was unable to provide documentation of GDR attempts for Risperdal, Venlafaxine or Lorazepam, and stated it was important to attempt GDR's to keep the medications at the lowest possible dose or possibly DC the medications. During an interview on 7/17/26 at 12:14 p.m. with LVN 6, LVN 6 stated side effects were documented in the Psych eMAR . LVN 6 stated if a resident had a side effect then staff would click yes indicated by a plus button on the computer system and stated she would then write a change of condition which included monitoring- alert charting, contact the provider and the resident's responsible party. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 West Lacey Blvd Hanford, CA 93230	
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/17/26 at 3:50 p.m. with the DON, Resident 5's Psych MAR dated 7/2026 was reviewed. Resident 5's Psych eMar indicated, .Ativan.Observe resident closely for significant side effects.Venlafaxine.Observe resident closely for significant side effects.Risperdal.Observe resident closely for significant side effects.+/- and indicated Y for NOC12 (night shift) for Risperdal side effect monitoring. The DON stated the process when nurses documented Y (yes) for side effect monitoring was to notify the physician of their finding and carry out any orders. The DON stated she believed the staff was interpreting and answering the side effect monitoring question as yes, they were checking off the box. The DON stated she believed the staff was interpreting and answering the side effect monitoring question in this manner because she was unable to find any documentation of actual side effects that had been documented for Resident 5. During a review of the facility's policy and procedure (P&P) titled, Tapering Medications and Gradual Drug Dose Reduction, dated July 2022, the P&P indicated, .All medications shall be considered for possible tapering. Tapering that is applicable to psychotropic medications are referred to as gradual dose reductions.Residents who use psychotropic medications shall receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.The staff and practitioner will consider tapering of medications as one approach to finding an optimal dose or determining whether continued use of a medication is benefiting the resident.The physician will order appropriate tapering of medications, as indicated. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated February 2025, the P&P indicated, .Residents do not receive psychotropic medications that are not clinically indicated and necessary. Medications in the following categories are considered psychotropic medications.Anti-psychotics.Anti-depressants.Anti-anxiety medications. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes.determining adequate indications for use.adequate monitoring for efficacy and adverse consequences.determining appropriateness of gradual dose reduction. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medications, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. Diagnosis alone does not necessarily warrant the use of psychotropic medication. If a psychiatric diagnosis is part of the rationale for the use of psychotropic medication, there will be sufficient supporting documentation that the resident meets the criteria for that diagnosis. Duplicate therapy (use of two or more medications of the same pharmacological class or category without a clear distinction of when one medication should be administered over another) is generally not indicated unless there is a documented clinical rationale for the use of multiple medications from the same class or with similar therapeutic effects. Residents receiving psychotropic medication are monitored and the response to treatment is documented. Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefitting the resident, to find an optimal dose, or in an effort to discontinue the medication. 3.During a concurrent observation and interview on 7/14/26 at 11:10 a.m. during initial tour in Resident 8'a room, Resident 8 was sitting at bedside and stated he had been in the facility for about five years. Resident 8 stated he goes to dialysis three times a week and was happy with the care he is receiving. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's admission Record [AR- a document containing resident profile information], dated 7/16/26, the AR indicated Resident 8 was admitted to the facility on [DATE]with diagnoses which included muscle weakness, end staged renal diseases (ESRD-irreversible kidney failure), and hemiplegia (paralysis of one side of the body) and hemiparesis (one-sided weakness). During a review of Resident 8's Order Details dated 7/15/26, the Order Detail indicated, Amitriptyline HCl Oral Tablet 100 MG . Related Diagnosis: Pain, Unspecified. During a concurrent interview and record review on 7/15/26 at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 8's medication orders were reviewed. LVN 1 stated Resident 8 was receiving amitriptyline. LVN 1 stated the medication's indication was for pain. LVN 1 stated Amitriptyline is an anti- depressant medication but the indication in the order is for pain. LVN 1 stated medication's indication was not appropriate. LVN 1 stated it was the responsibility of the licensed nurse receiving the medication order to ensure a proper diagnosis or indication for medication to monitor side effects and monitor effectiveness of medication. During an interview on 7/16/26 at 1:45 p.m. with LVN 3, LVN 3 stated it was important to ensure psychotropic medications had appropriate diagnosis or indication to monitor for side effects of medications. LVN 3 stated it was important to ensure medication was monitored for effectiveness. During an interview on 7/17/26 at 5:22 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON and ADON stated the expectation was for the licensed nurse receiving the medication order to clarify with the Medical Doctor (MD) giving the order of the complete and appropriate diagnosis or indication of medication. The DON stated appropriate diagnosis or indication of medication to ensure residents were ordered and treated with the right medication and to monitor effectiveness of medication. 4. During a concurrent observation and interview on 7/14/26 at 9:20 a.m. during initial tour in Resident 57's room, Resident 57 was lying in bed watching TV. Resident 57 stated she had been in the facility for couple of months. Resident 57 stated she was working with therapy due to a fall at home. Resident 57 stated she uses a wheelchair and a walker for transfer and ambulation. During a review of Resident 57's AR, dated 7/16/26, the AR indicated, Resident 57 was admitted to the facility on [DATE] with diagnoses which included muscle wasting and atrophy (muscle loss or shrinking muscles), depression (serious mood disorder that causes ongoing sadness and a loss of interest in things you once enjoyed) and muscle weakness. During a review of Resident 57's Medication Review Report [MRR], dated 7/17/26, the MRR indicated, .Sertraline HCl[hydrochloride-an active medicine combined with a safe form of hydrochloric acid to turn it into a stable, water-soluble salt] Oral Tablet 100 MG [milligram-unit of measurement] Give 1 (one) tablet by mouth one time a day .Order date: 6/16/26, Start Date: 6/17/26. During a concurrent interview and record review on 7/15/26 at 2:04 p.m. with LVN 4, LVN 4 reviewed Resident 57's clinical record titled MRR. LVN 4 stated Resident 57 is currently receiving sertraline medication for depression. LVN 4 stated she did not find monitoring order for non-pharmacological (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention and there should be. LVN 4 stated it was important to have monitoring in place for non-pharmacological intervention to provide residents with alternate interventions like listening to them verbalize their feelings and redirecting to activities. LVN 4 stated it was the responsibility of licensed nurses to ensure there was monitoring order for non-pharmacological interventions During an interview on 7/17/26 at 5:32 p.m. with DON and ADON, DON and ADON stated it was important to monitor non-pharmacological interventions to ensure to try something other than medication first. The DON and ADON stated the main goal were to always try to redirect residents' behaviors without medications first. DON and ADON stated the non-pharmacological interventions would be initiated at the time the medication order was received and the nurse receiving the order was responsible in initiating the monitoring. During a review of facility policy and procedure (P&P) titled, Psychotropic Medication Use, revision date 2/25, the P&P indicated, .When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts, and documents an evaluation of the resident. Adequate Indications for Psychotropic Medication Use.an assessment of the resident's condition and therapeutic goals.a determination that non-pharmacological intervention are clinically contraindicated.The clinical rationale for the use of psychotropic medication. Documentation must include that behavioral (non-pharmacological) interventions were attempted but not successful, and these interventions were deemed clinically contraindicated.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to prepare food in a form designed to meet an individual resident's needs by preparing pureed zucchini that did not maintain the consistency required for a prescribed pureed diet for one of nine residents (Resident 10). This failure had the potential to increase the risk of aspiration (food or liquid entering the airway instead of the stomach) by not providing food in the consistency required for the residents prescribed pureed diet. Findings: During a concurrent observation and interview on 7/15/26 at 11:41 a.m. with the Certified Dietary Manager (CDM) during lunch tray line, the first pureed meal tray assembled for meal service for Resident 10, contained liquid from the pureed zucchini that had spread throughout the bottom of the clear container. The CDM opened the meal tray for further observation. The pureed zucchini appeared thin, runny and did not maintain its intended shape. When asked how a properly prepared pureed vegetable should appear, the CDM stated it should be smooth, cohesive and hold together, but not be runny. The CDM stated the pureed zucchini observed at that time did not appear as it should. The CDM discarded the pureed zucchini and had it remade to the correct consistency for Resident 10 and the remaining eight residents receiving a pureed diet. During a review of Resident 10's Meal Ticket dated 7/15/26, the Meal Ticket identified Resident 10's diet order as puree, fortified, with nectar thick liquids. During an interview on 7/15/26 at 3:02 p.m. with KS 3, KS 3 stated when preparing pureed foods, she aimed for a nectar-like consistency when blending. KS 3 stated she learned how to prepare pureed foods a long time ago through her experience working in the kitchen. KS 3 stated she did not prepare the pureed zucchini served during the lunch meal service. KS 3 stated pureed foods should hold their form and should not run together. KS 3 stated she believed the pureed zucchini became runny because it sat while in the warmer while waiting for tray line and accumulated additional moisture. KS 3 stated it was important for puree foods to maintain their form because residents would not find runny food appealing. During an interview on 7/15/26 at 3:47 p.m. with the CDM and the Registered Dietitian (RD), the CDM stated pureed foods should be smooth to promote safe swallowing. The CDM stated the pureed zucchini observed during the lunch tray line on 7/15/26 did not meet the required standard because it did not hold its shape. The CDM stated the spoon tilt test should be used to verify the proper consistency of pureed foods rather than relying solely on a visual inspection. The RD conformed pureed foods should maintain their shape and stated foods that are too thin increase the risk of aspiration. During a review of the facilities policy and procedure (P&P) titled, Regular Pureed Diet, dated 2023, the P&P indicated, the pureed diet is a regular diet that has been designed for residents who have difficulty chewing and or swallowing. The texture of the food should be of a smooth and moist consistency and able to hold its shape. During a review of the facilities policy and procedure (P&P) titled, Nutritional Management of Thickened Liquids, dated 2023, the P&P indicated, 2. Mildly thick/nectar thick liquids flows off spoon. residents on thickened liquids should avoid foods with mixed consistencies. During a review of facilities Recipe: Pureed (IDDSI Level 4) Vegetables dated 2024, the Recipe indicated, the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky and should not weep. The finished pureed item must pass IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure, and spoon tilt tests).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective infection prevention and control program for two of five sampled residents (Resident 6 and 12) when:1. Licensed Vocational Nurse (LVN) 5 checked Resident 6's blood sugar using a glucometer (a portable medical device used to measure the amount of sugar in the blood) and did not properly disinfect the glucometer after use.2. LVN 5 checked Resident 12's blood sugar using a glucometer and did not properly disinfect the glucometer after use.This failure had the potential to put residents at risk of cross contamination (the process by which germs are unintentionally transferred from one substance or object to another, with harmful effect) that could result in the transmission of infections and pathogens (germs that invade the body and cause illness) which could lead to infection, hospitalization, or death.1. During a review of Resident 6'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 7/16/26, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition where the body cannot properly process sugar for energy, causing it to build up in the bloodstream) with diabetic neuropathy (prolonged, high blood sugar from diabetes has caused structural and functional damage to the body's nerves), urinary tract infection, cerebral infarction (stroke), hyperlipidemia (too much cholesterol and fats circulating in the blood). During a concurrent observation and interview on 7/15/26 at 10:53 a.m. with LVN 5, in Resident 6's room, LVN 5, was observed checking Resident 6's blood sugar using a glucometer. LVN 5 stated Resident 6's blood sugar was 291. LVN 5 administered 8 units (unit of measure) of Novolin R(a form of insulin used to lower blood sugar). After using the glucometer, LVN 5 wrapped the glucometer in a bleach wipe, set a timer, and placed the glucometer on the medication cart. 2. During a review of Resident 12's AR dated 7/16/26, the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus, urinary tract infection, hyperlipidemia, chronic kidney disease (when the kidneys are damaged and slowly lose the ability to properly filter waste and extra fluid from the blood). During a concurrent observation and interview on 7/15/26 at 11:08 a.m. with LVN 5, in Resident 12's room, LVN 5 was observed checking Resident 12's blood sugar using a glucometer. LVN 5 stated Resident 12's blood sugar was 256. LVN 5 administered 8 units of Novolin R. After using the glucometer, LVN 5 wrapped the glucometer in a bleach wipe, set a timer, and placed the glucometer on the medication cart. During a concurrent interview and review on 7/15/26 at 11:17 a.m. with LVN 5, the manufacturer instructions for the Bleach Germicidal Wipes were reviewed. LVN 5 stated the process after using a glucometer to check blood sugars, was to wrap the glucometer with the bleach wipe and let stand for 3 minutes. After reviewing instructions on Bleach Germicidal Wipes container with LVN 5, LVN 5 stated she did not wipe the glucometer entirely before wrapping it with the bleach wipe and setting the timer for 3 minutes. LVN 5 stated it was important to clean the glucometer machine to disinfect and to prevent the spread of germs especially since going into another room.During an interview on 7/16/26 at 8:56 a.m. with the Director of Nursing (DON), the DON stated her expectation was for staff to disinfect the glucometer according to manufacturer instructions. The DON stated it was important for staff to disinfect the glucometer according to manufacturer instructions, for infection control. The DON stated staff needed to sanitize glucometers properly before taking it to the next patient. During a review of facility provided document titled, [Brand name] HEALTHCARE .Germicidal Wipes., (undated), the document indicated, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.Disinfection.Wipe hard, nonporous surface to be disinfected.Special Instructions for Using This Product to Clean ad Decontaminate.on .Objects Soiled with Blood/Body Fluids.Cleaning Procedure: Blood and other body fluids must be thoroughly cleaned from surfaces and other objects before applying this product. During a review of the facility's policy and procedure (P&P) titled, Blood Sampling-Capillary (Finger Sticks), dated September 2014, the P&P indicated, .The purpose of this procedure is to guide the safe handling of capillary-blood sampling devices to prevent transmission of bloodborne diseases to residents and employees.Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses.Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set Assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of eight sampled residents (Resident 20) when Resident 20's Functional Limitation in Range of Motion was inaccurately coded in the quarterly MDS assessment dated [DATE]. This failure had the potential for Resident 20's need not monitored and met which could lead to further decline in function of lower extremities. During a review of Resident 20's admission Record AR-document containing resident profile information, dated 7/16/26, the AR indicated Resident 20 was admitted to the facility on [DATE], with diagnoses which included abnormalities of gait and mobility, atherosclerosis of native arteries of extremities, bilateral legs (hardening and narrowing of the arteries in both legs), muscle weakness and pain. During a review of Resident 20's MDS assessment dated [DATE], the MDS section C indicated Resident 20 had a Brief Interview for Mental Status (BIMS-assessment of cognitive status for memory and judgment) assessment 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), which indicated Resident 20's cognition was moderately impaired. During a concurrent observation and interview on 7/14/26 at 9:35 a.m. during the initial tour in Resident 20's room, Resident 20 was lying in bed and stated he just finished his bed bath. Resident 20 stated he did not take showers because it was too hard for him to sit in the shower chair for a long time. Resident 20 stated he had multiple strokes few years ago and used to be able to move his left leg. Resident 20 stated he cannot move his left leg and his right leg was also getting weaker and not able to bear weight. Resident 20 stated staff had to use a mechanical lift to transfer him out of bed. During an interview on 7/15/26 at 2:43 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was familiar with Resident 20's care. CNA 1 stated Resident 20 was alert and able to verbalize needs and concerns. CNA 1 stated Resident 20 did not like to get out of bed and had to use a mechanical lift for transfers because his legs are weak. During an interview on 7/15/26 at 3:24 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was familiar with Resident 20's care. LVN 1 stated Resident 20's left leg was weaker than the right leg. LVN 1 stated Resident 20 was always in bed, and it was his choice not to get out of bed. LVN 1 stated she had not seen Resident 20 out of his room and was not sure if staff uses mechanical lift for transfers. During a concurrent observation and interview on 7/16/26 at 1:16 p.m. with Minimum Data Set Regional Consultant (MDSRC), the MDSRC stated the MDS nurse was on vacation, and she was filling in until MDS nurse returns. The MDSRC reviewed Resident 20's quarterly MDS assessment dated [DATE] and stated the assessment indicated Resident 20 did not have limitations on their lower extremities. The MDSRC assessed Resident 20's mobility of his lower extremities. The MDSRC stated the assessment was not accurate, Resident 20 was not able to move his left leg, and the right leg was also weak. The MDSRC stated the assessment should have indicated there was limitation on lower extremities. The MDSRC stated accurate and complete MDS assessment was important for residents to receive proper care. During an interview on 7/17/26 at 5:45 p.m. with the Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON stated her expectation was to ensure MDS assessments are accurate. The DON stated each person completing a portion of the MDS are responsible in ensuring their assessments are complete and accurate. The DON stated MDS was very important because it creates an accurate picture of the residents and ensures proper care was provided. During a review of (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, review date 10/24, the P&P indicated, .Any person who completes a portion of the MDS assessment. is required to sign the assessment certifying the accuracy of portion of that assessment. The information captured on the assessment reflects the status of the resident during the observation [look-back] period of the assessment.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 8Number of residents cited: 1Based on observation, interview, and record review, the facility failed to timely revise and implement a person-centered comprehensive care plan for one of eight sampled residents (Resident 2) when Resident 2's care plan for enteral nutrition (tube feeding [soft, flexible tube inserted directly into the stomach or small intestine]- way to get liquid food and nutrients directly into the stomach or small intestine when resident cannot safely eat by mouth) was not updated and did not accurately reflect the physician's order for Resident 2's enteral nutrition.This failure had the potential to result in Resident 20's needs not be met.During an observation on 7/14/26 at 9:29 a.m. during initial tour in Resident 2's room, Resident 2 was observed lying in bed, eyes closed and head of bed elevated. Resident 2 connected to tube feeding machine and feeding formula infusing at 65 milliliter (ml-unit of measurement) per hour. Resident 20 did not answer questions asked. During a review of Resident 2's admission Record [AR- a document containing resident profile information], dated 7/16/26, the AR indicated, Resident 20 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (complete or severe paralysis of one entire side of the body) and hemiparesis (weakness on one side of the body), dysphagia (difficulty swallowing), gastrostomy (small, safe path made into the stomach through the belly to put food, drinks, and medicine straight inside) and anorexia (complete loss of appetite).During a review of Resident 2's Order Details [physician order], undated, the Order Detail indicated . Enteral feeding with [brand name] . at 65 ml [milliliter-unit of measurement]/hr [hour] x16 hrs [hours].During a review of Resident 2's Care Plan, date initiated 03/11/2024, Revision on 03/13/2025, the Care Plan indicated, .Interventions. bolus feed [quick tube-feeding method] & Flush as ordered by MD.During a concurrent interview and record review on 7/15/26 at 3:17 p.m. with Licensed Vocational Nurse (LVN)1, Resident 2's clinical record titled care plan: Enteral nutrition was reviewed. LVN 1 stated Resident 2 is on continuous feeding. LVN 1 stated Resident 2's tube feeding used to be bolus feeding but was changed to continuous. LVN 1 reviewed Resident 2's physician order for enteral feeding and stated the order for continuous feeding was dated 4/1/26. LVN 1 stated it was the responsibility of all licensed nurses to revise and update care plan. LVN 1 stated care plan should be person-centered to meet resident's needs.During an interview on 7/17/26 at 5:22 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON stated care plan should be updated and revised as soon as a change happens. The DON stated it was every licensed nurse's responsibility to revise and update a care plan. The DON stated it was important to keep care plans up to date to provide proper care and care for residents.During a review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revision date 3/22, the P&P indicated, . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. When possible, interventions address the underlying source(s) of the problem(s), not just symptoms or triggers. Assessments of residents are on-going, and care plans are revised as information about the residents and the resident ?s condition change .		

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NAME OF PROVIDER OR SUPPLIER Hanford Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1007 West Lacey Blvd Hanford, CA 93230	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 8Number of residents cited: 2Based on observation, interview, and record review, the facility failed to ensure nail care was provided for two of eight sampled residents (Resident 11 and Resident 53) when Resident 11 and Resident 53's fingernails were long and dirty with dark brown built up underneath their nails.This failure had the potential for Resident 11 and Resident 53 in sustaining avoidable skin related injuries like cuts, skin tears, scrapes and scratches which can lead to skin infection (invasion and growth of germs in the body).During a concurrent observation and interview on 7/4/26 at 9:28 a.m. during initial tour in Resident 11's room, Resident 11 was lying in bed with eyes open. Resident 11 stated he was in the hospital due to poor circulation in his lower legs and had to amputate both legs above the knee. Resident 11 was observed with several skin tears and scabs on different stages of healing. Resident 11 was observed with long and dirty fingernails. Resident 11 stated his nails are long and dirty and needed to be trimmed and cleaned. Resident 11 stated he did not remember when his nails were last cleaned and trimmed. Resident 11 stated he wanted his nails trimmed and cleaned because he tends to scratch himself.During a review of Resident 11's admission Record [AR-a document containing resident profile information], dated 7/16/26, the AR indicated, Resident 11 was admitted to the facility on [DATE] with diagnoses which included muscle weakness, peripheral vascular disease (a slow, progressive blood circulation disorder), and atherosclerotic heart disease (hardening of arteries cause by hardening of fatty plaque [a sticky gunk made of fat and cholesterol that builds up inside your blood vessels]).During a review of Resident 11's Minimum Data Set ((MDS - a resident assessment tool used to identify cognitive and physical function) assessment, dated 6/29/26, indicated Resident 11's Brief Interview of Mental Status assessment (BIMS- assessment of cognitive status for memory and judgement) scored 9 of 15 (a score of 13-15-indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07-indicates severe impairment). The BIMS assessment indicated Resident 11's cognition was moderately impaired. During a concurrent observation and interview on 7/14/26 at 10:14 a.m. during initial tour of the facility in Resident 53's room, Resident 53 was found sitting in her wheelchair. Resident 53's fingernails were long, thick and yellowish in color with brownish colored built up underneath the nails, Resident 53 stated she would like to have her nails clipped. Resident 53 stated she could not remember when her nails were trimmed last. Resident 53 stated she had mentioned it to several people she wanted her nails clipped but there was no answer from staff.During a review of Resident 53's AR, dated 7/16/26, the AR indicated, Resident 53 was admitted to the facility on [DATE] with diagnoses which included muscle wasting and atrophy (shrinking and losing muscle size and strength), scoliosis (a sideways curve of the backbone.), and spondylosis without myelopathy, lumbosacral region(the age-related wear and tear of the lower back (lumbar spine) and tailbone (sacrum) area).During a review of Resident 53's MDS assessment dated [DATE], indicated Resident 53's BIMS scored 14 of 15. The BIMS assessment indicated Resident 53 is cognitively intact. During an interview on 7/15/26 at 2:43 p.m. with Certified Nurse Assistant (CNA) 1, CNA 1 stated nail care was provided once a week on Sunday. CNA 1 stated CNAs can only trim non-diabetic residents' nails and licensed nurses take care of diabetic residents. CNA 1 stated long fingernails can cause infection if resident scratches self especially if nails are dirty. During an interview on 7/15/26 at 2:59 p.m. with CNA 2, CNA 2 stated nail care provided to non-diabetic residents and not sure how often they have to trim resident nails. CNA 2 checked Resident 11's nails and stated, needs to be trimmed and cleaned. CNA 2 stated dirty and long nails can get resident sick if he scratches his skin and can lead to (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection. During a concurrent observation and interview on 7/15/26 at 3:25 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 11's fingernails are long and dirty. LVN 1 stated licensed nurses trim nails of diabetic residents. LVN 1 stated residents with long nails may scratch self and may lead to infection. LVN 1 stated Resident 11's fingernails should have been cleaned and trimmed. During an interview on 7/16/26 at 11:09 a.m. with Infection Preventionist (IP), the IP stated nail care is provided to residents on their shower days and every Sunday. The IP stated there was no documentation for nail care provided to residents. The IP stated he did not remember any residents complained to him about needing their nails trimmed. The IP stated CNAs may clean, trim or file resident's nails except diabetic residents, only licensed nurses may trim fingernails of diabetic residents. During an interview on 7/16/26 at 11:30 a.m. with CNA 4, she stated, I trim resident fingernails once a week. CNA 4 stated resident fingernails are checked on their shower days making sure nails are cleaned and trimmed. CNA 4 stated long and dirty fingernails could cause infection when a resident scratch self with their long and dirty fingernails. During an interview on 7/16/26 at 1:50 p.m. with LVN 3, she stated CNAs trim and file fingernails of non-diabetic residents and licensed nurses take care of diabetic residents' fingernails. LVN 3 stated she was not sure how often nail care is provided. LVN 3 stated long fingernails could potentially cause injury to residents, they can scratch their skin which could lead to infection especially if their nails are dirty. LVN 3 stated CNAs could let licensed nurses know when a diabetic resident needed their fingernails trimmed. During an interview on 7/17/26 at 5:35 p.m. with Director of Nursing (DON) and Assistant Director of Nursing (ADON), the DON stated her expectation was for staff to keep residents' fingernails trimmed, neat and clean. The DON stated CNAs should be cleaning and trimming residents' nails on their shower days and every Sunday. The DON stated residents could scratch their skin and may lead to infection. During a review of facility's policy and procedure (P&P) titled, Care of fingernails/Toenails, revised date 10/10, the P&P indicated, .Nail care includes daily cleaning and regular trimming. Proper nail care aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Notify the supervisor if the resident refuses the care.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the environment was free of hazards and adequate supervision was provided to prevent accidents for one of three residents, Resident 96, when nursing staff had assessed Resident 96 as a high risk for falls, were aware of Resident 96's history of falls, and previous Left hip fracture and failed to provide the level of supervision necessary to meet Resident 96's needs. The Occupational Therapy and Physical Therapy evaluation indicated Resident 96 required moderate assistance with toileting and was not independent with transfers between the bed and wheelchair. Nursing staff failed to implement supervision and interventions to address Resident 96's needs. The Minimum Data Set (MDS - a health assessment used in nursing homes to track patient needs, care plans, and health changes.) assessment indicated staff were to provide contact assistance with Activities of Daily Living (ADL - the basic self-care tasks people do every day, such as eating, bathing, and dressing etc.) and interventions were not implemented. These failures resulted in unwitnessed falls on [DATE] and [DATE] inside Resident 96's room, and [DATE] on the hallway, outside Resident 96's room. The fall of [DATE] approximately at 5:28 a.m. occurred after Resident 96 slid out from her wheelchair and was found sitting next to her wheelchair. After complaining of severe pain in the Right Hip and Right leg, Resident 96 was later sent to the hospital via ambulance following the fall incident. Resident 96 was diagnosed with Right hip fracture in the Emergency Department (ED). Ortho surgeon consulted on [DATE] and underwent surgery for an Open Reduction and Internal Fixation (ORIF - is a type of surgery used to stabilize and heal a broken bone) and pin placement. Resident 96 was hospitalized from [DATE] to [DATE] for 15 days and with limitations of movement, mobility, pain and suffering. Resident 96 was discharged back to the skilled nursing facility with hospice care following hospitalization. FINDINGS: During a review of Resident 96's admission Record (AR - a document with personal and medical information), dated [DATE], the AR indicated Resident 96 was a female, 83-years-old and was admitted [DATE] to the facility with diagnoses which included Displaced Fracture of Greater Trochanter of Left Femur, subsequent encounter for closed fracture with routine healing (a resident in the recovery phase for a broken left hip bone, where the broken piece moved out of place but is healing normally), Disorder of bone density and structure (the bones lose their solid inner strength, becoming thin, fragile, and porous like a sponge or an open honeycomb), and Dementia (a progressive state of decline in mental abilities). During an interview on [DATE] at 3:15 p.m. with Licensed Vocation Nurse (LVN) 7, LVN 7 stated Resident 96 had an unwitnessed fall on [DATE] approximately 5:28 a.m. and LVN 7 was the nurse in charge of Resident 96. LVN 7 stated Certified Nursing Assistant (CNA) 9 notified LVN 7 of Resident 96's unwitnessed fall. LVN 7 stated Resident 96 fell in the hallway outside of Resident 96's room, next to the door. LVN 7 stated Resident 96 was lying on her right side and right arm supporting the body. LVN 7 stated Resident 96 reported she slid out of her wheelchair in the hallway. LVN 7 stated Resident 96 was evaluated, a head-to-toe assessment was done, and Resident 96 did not complain of pain or discomfort at the time of fall. LVN 7 stated Resident 96 was transferred to her wheelchair with the assistance of CNA 9. LVN 7 stated Resident 96 kept saying and repeating why did this happen again. LVN 7 stated Resident 96 did not complain of pain until after being transferred to the wheelchair. LVN 7 stated Resident 96 complained of severe pain while sitting upright in her wheelchair and movement of her right leg. LVN 7 stated Resident 96 was administered pain medication as needed but was ineffective. LVN 7 stated on [DATE] the physician was notified and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered Resident 96 to be transferred to acute care hospital for further evaluation. LVN 7 stated Responsible Party (RP) and Director of Nursing (DON) were made aware of the fall incident. LVN 7 stated Resident 96's fall could have been prevented with nonskid surface pad on seat of wheelchair. LVN 7 stated before the fall incident, Resident 96 was alert and consistently seated in her wheelchair. LVN 7 stated Resident 96 self-transferred from bed to wheelchair, used the wheelchair to access the toilet and propel self around the facility. LVN 7 stated Resident 96 enjoyed spending time with other residents, singing and visiting in the front lobby during her free time. During an interview on [DATE] at 5:01 p.m. with CNA 9, CNA 9 stated she was the CNA assigned to care for Resident 96 on [DATE], the day of the fall from the wheelchair. CNA 9 stated Resident 96 was found in a seated position on the floor in the hallway outside of Resident 96's room on [DATE] at approximately 5:28 a.m. CNA 9 stated she assisted the Charge nurse in transferring Resident 96 back into the wheelchair. CNA 9 stated Resident 96 was a fall risk, and CNAs were instructed to monitor her closely. CNA 9 stated Resident 96 required supervision when transferring from bed to wheelchair. CNA 9 stated Resident 96 sometimes forgot to use the call light for assistance and independently transferred from bed to wheelchair without first calling for assistance. CNA 9 stated Resident 96 was non ambulatory and used a wheelchair to go to the toilet for toileting and mobility throughout the facility. CNA 9 stated Resident 96 liked to do things independently. CNA stated Resident 96 was toileted before 5:28 a.m. CNA 9 stated the use of a chair alarm could have helped prevent the fall. During a concurrent interview and record review on [DATE] at 9:38 am with LVN 4, Resident 96's NURSING-FALL RISK OBSERVATION/ASSESSMENT(NFRA), dated [DATE] was reviewed. The NFRA indicated Resident 96 had a high fall risk score of 16. LVN 4 stated she had provided care to Resident 96 many times. LVN 4 stated Resident 96 had a history of falls at home and had been placed on fall precautions while in the facility. LVN 4 stated Resident 96 had experienced repeated falls in the facility on [DATE], [DATE] and [DATE]. LVN 4 stated Resident 96 had not consistently used the call light for assistance and preferred to do activities independently. LVN 4 stated Resident 96's required supervision or touching assistance (a staff provides verbal cues and or contact guard assistance as the resident completes activity) during transfers between surfaces. LVN 4 stated Resident 96 experienced a mental and physical decline after the Right hip surgery following the unwitnessed fall on [DATE] and upon returning to the facility on [DATE] under Hospice care (a comfort-focused medical treatment and support). LVN 4 stated when Resident 96 was first admitted to the facility on [DATE], Resident 96 was alert and oriented to person, place and time with occasional forgetfulness, verbally interactive with other residents and staff, and able to self-propelled in her wheelchair. LVN 4 stated following the Right hip surgery, Resident 96 had been oriented only to person, had become very weak and fatigued easily. LVN 4 stated Resident 96 complained of pain during repositioning and had wanted to sleep more. LVN 4 stated Resident 96's fall was not preventable because Resident 96 was noncompliant with using the call light for assistance and preferred to do activities independently. During a concurrent interview and record review on [DATE] at 10:42 a.m. with the Occupational Therapist (OT), Resident 96's Occupational Therapy Medicare OT Evaluation & Plan of Treatment (OTME), dated [DATE] was reviewed. The OTME indicated Resident 96's bilateral upper extremities strength was graded three out of five (the resident can independently move bilateral upper extremities, but it is weak and cannot lift heavy things). Resident 96's standing balance during ADL was poor. Resident 96's toileting transfer was minimal to moderate assistance and facility staff assistance was necessary because Resident 96 was unable to complete the task safely without assistance. The OT stated he performed OTME for Resident 96 on [DATE]. The OT stated Resident 96 needed reinforcement regarding safety awareness and the importance of using the call light for assistance. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The OT stated Resident 96's therapy treatment goals were provided to improve independence with ADL, increase safety awareness, improve standing balance and activity tolerance, reinforce safe techniques, and reduce the risk of falls. The OT stated Resident 96 showed deficits in strength, balance, mobility, and cognition which affected daily activities, mobility, and safety. During a concurrent interview and record review on [DATE] at 2:17 p.m. with the Physical Therapist (PT), Resident 96's Physical Therapy Medicare PT Evaluation and Plan of Treatment (PTME), dated [DATE] was reviewed. The PTME indicated, Resident 96's bilateral lower extremity was graded three out of five (the resident can move their legs against gravity but cannot resist any extra pressure or resistance). Resident 96's sitting and standing balance was poor, and her coordination was impaired. Resident 96 was not independent and required minimal assistance to perform bed mobility and transfer task safely. The PT stated he performed PTME for Resident 96 on [DATE]. The PT stated Resident 96 was not supposed to self-transfer and required staff assistance with transfers. The PT stated Resident 96's therapy treatment goals were to improve safety awareness, balance, emphasize standing and transfer task. During an interview on [DATE] at 5:22 p.m. with the DON, the DON stated Resident 96 had an unwitnessed fall on [DATE] at 9:30 p.m. The DON stated CNA 3 found Resident 96 sitting on the floor and was not wearing nonskid socks. The DON stated during the interview with Resident 96, Resident 96 reported she was trying to reach something in the drawer and her feet slipped out from underneath her, causing her to fall. The DON stated Resident 96 was assessed as high fall risk prior to the fall on [DATE]. The DON stated Resident 96 should have called for help but did not call for help. The DON stated Resident 96 was toileted 10mins before the fall. The DON stated Resident 96 was independent with transfer and toileting. The DON stated Resident 96 was on fall risk precaution. The DON stated the immediate actions taken after the fall were keeping the bed low, Call light within reach, keeping personal belongings within reach. The DON stated the fall care plan was updated and a new intervention was added with a nonskid sock every evening as tolerated. The DON stated the fall care plan was effective in preventing falls. The DON stated the fall was not preventable because every fall was a different scenario and with different new fall interventions implemented. The DON stated Resident 96 was non-compliant with using the call light for assistance and Resident 96 could self-transfer from bed to wheelchair. The DON stated on [DATE] at 2:15 p.m. Resident 96 had a second unwitnessed fall. The DON stated CNA 7 found Resident 96 was seated on the floor, facing the bathroom. The DON stated Resident 96 reported to the charge nurse she slipped during self-transfer from bed to wheelchair and hit her head. The DON stated Resident 96 sustained a reddish discoloration on her right forehead. The DON stated Resident 96 was transferred to the acute care hospital for a higher level of care. The DON stated Resident 96 returned to the facility on the same day with no new orders and to continue with care plan. The DON stated Resident 96's fall care plan was updated, and new interventions were added, including monitoring bowel and bladder needs every two hours and enrolling Resident 96 on the falling star program (a falling safety system used in health care facility to identify residents who have a high risk of falling). The DON stated Resident 96's falling star program which included the following interventions such as a star to be placed on name plate next to the door and on wheelchair, Staff to assist Resident 96 to the bathroom before meals, after meals, bedtime and as needed, offer to lay resident down after all meals, encourage residents to attend activities of choice and resident not to be left alone in room while out of bed. The DON stated a falling star program was like putting an extra set of eyes on Resident 96 and there was no documentation on how often the staff monitored Resident 96. The DON stated the fall care plan was effective in preventing falls. The DON stated the fall was not preventable because every fall was with a different scenario and with different new fall interventions. The DON stated Resident 96 required (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supervision and assistance with transfers and toileting but Resident 96 was noncompliant with using the call light for assistance. The DON stated Resident 96 could self-transfer from bed to wheelchair and could toilet independently. The DON stated on [DATE] at approximately 5:28 a.m. Resident 96 had a third unwitnessed fall. The DON stated CNA 9 found Resident 96 on the floor in the hallway outside the resident's room. The DON stated when LVN 7 assessed resident 96 there were no visible injuries. The DON stated Resident 96 reported to LVN 7, Resident 96 slid down from her wheelchair and fell to the floor. The DON stated Resident 96 was transferred back to her wheelchair by the nursing staff. The DON stated Resident 96 continued to experience pain in the Right hip and Right leg and her pain medication was ineffective. The DON stated LVN 7 notified the physician and Resident 96 was transferred to the acute care hospital for further evaluation. The DON stated Resident 96 was diagnosed with a Right hip fracture. The DON stated the fall was not preventable because every fall was with a different scenario and with different new fall interventions. The DON stated one on one supervision and the use of tab alarm was not considered as a fall intervention because Resident 96 was alert, independent with bed mobility and transfer. The DON stated one on one supervision and the use of tab alarm would have limited Resident 96's ability to move freely within her room and throughout the facility. The DON stated Resident 96 had the right to move freely and independently. The DON stated Resident 96's fall care plan was updated, and a new intervention was added including non-skid pad to the wheelchair seat, medication review by pharmacy, falling star program and a room change to a room near the nurse's station upon return from the acute care hospital. During a concurrent interview and record review on [DATE] at 3:10 p.m. with the Minimum Data Set Regional Consultant (MDSRC - a specialized nurse in skilled nursing facilities who oversees the mandated resident assessment), Resident 96's Section GG - Functional Abilities (SGFA), dated [DATE] was reviewed. The SGFA indicated toileting hygiene, toilet transfer and chair/bed to chair transfer scores were four. The MDSRC stated a score of four means supervision or touching assistance. The MDSRC stated nursing staff must stay with Resident 96 to provide verbal cues or contact guard assistance (a caregiver keeps one or two hands on a resident's body to steady balance or prevent a fall) as Resident 96 completes activity. The MDSRC stated Resident 96's fall care plan was reflected on the Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment and was communicated to the staff, Resident 96 required supervision and physical assistance during transfers. During a review of Residents 96's MDS assessment dated [DATE], indicated Resident 96's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 10 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 96's cognition was moderately impaired. During a record review of Resident 96's Hospital record titled History and Physical (H&P), dated [DATE], the H&P indicated, . Date of service [DATE]. Chief Complaint Episode of fall. 83-years-old Hispanic female brought in from. post-acute skilled nursing facility after an episode of fall. baseline history of hypertension and dementia. Patient is oriented to herself only. Right hip x-ray and CT of hip. reported right hip intertrochanteric fracture. Orthopedic physician. has been consulted. surgery has been scheduled. tomorrow. During a review of Resident 96's Hospital record titled Ancillary Notes - OT (ANOT), dated [DATE], the ANOT indicated, . The patient is a [AGE] year-old Hispanic female brought in. from skilled nursing facility after an episode of fall. baseline history. dementia. Pt is now s/p right femoral trochanteric nailing. Rehab reason for referral: Evaluation and treatment. Not oriented to time, not oriented to situation. Evaluation assessment: Co-treated with PT due to concerns of fatigue. Pt demonstrated poor condition throughout due to the frequent verbal cues and repeated instructions the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	therapist provided. dementia which impedes her ability to be independent. Pt's family came in during the therapy session to observe. Pt was transferred to EOB [Edge of bed] and attempted to stand. unsuccessful. Pt will benefit from continued skilled therapy. to address functional mobility deficits, safety and independence. During a review of Resident 96's Hospital record titled Ancillary Notes - PT (ANPT), dated [DATE], the ANPT indicated, . Evaluation assessment: Patient received in room, agreeable to PT/OT. She presents with impaired functional mobility associated to pain elicited on R hip during mobility tasks. patient would benefit from continued skilled therapy. to address functional mobility deficits, safety and independence. During a review of Resident 96's Hospital record titled Discharge Summaries Notes (DSN), dated [DATE], the DSN indicated, .admit date : [DATE]. Reason for admission: Intertrochanteric fracture of right hip. Final Diagnosis. Intertrochanteric fracture of right hip. Fall. Encounter for palliative care. Leg pain. Hospital Course. patient is a [AGE] year-old Hispanic female. brought in from. skilled nursing facility after an episode of fall. Patient is status post ORIF. on [DATE]. postoperative patient had an episode of blood loss anemia, Acute Kidney Injury (AKI - sudden loss of kidney function) on Chronic Kidney Disease Stage IV (CKD stage IV - severe kidney damage) requiring starting hemodialysis (a life-saving medical treatment that uses a machine and a special filter to clean your blood when your kidneys have failed) in the hospital. recommended hospice which the family accepted. Patient is cleared to go back on [DATE] with hospice in the SNF. She is medically stable. During a concurrent observation and interview on [DATE] at 9:22 a.m. with Resident 96 inside Resident 96's room, Resident 96 was in bed and eyes closed. Resident 96 was interviewed by utilizing translating service California Department of Public Health Translator (CDPHT - a language professional who helps people with limited English skills understand health information) via phone. Resident 96 stated her first name, was unable to answer what happened to her and took a long time to respond. Resident 96 was falling asleep during the interview, and no other questions were asked. During a review of Resident 96's Care Plan Report (CPR), the CPR indicated, on [DATE] the following fall interventions were implemented such as keeping bed in low position with brakes locked, keeping call light and personal items frequently used within reach, monitoring changes in condition affecting risk for falls and notify physician if observed. On [DATE] fall intervention to provide proper, well-maintained footwear as indicated (Non-skid Socks etc.) On [DATE] room change was initiated for Resident 96 to be closer to the nurse's station. On [DATE] fall interventions were to apply nonskid tape to left side of bed, and red tape to wheelchair brakes. On [DATE] Resident 96 was encouraged to wear nonskid socks every night as tolerated. On [DATE] Resident 96 to be enrolled in the Falling star program (a fall safety system used in health care facility to identify residents who have a high risk of falling). During an interview on [DATE] at 8:38 a.m. with CNA 3, CNA 3 stated she was the CNA assigned to Resident 96 when Resident 96 had an unwitnessed fall on [DATE] at 9:30 p.m. CNA 3 stated Resident 96 was found sitting on the floor between the bed and the wheelchair. CNA 3 stated she immediately notified the charge nurse, who assessed Resident 96 and Resident 96 was assisted back to her bed. CNA 3 stated Resident 96 was on Fall precaution but did not remember if she was on the falling star program. CNA 3 stated Resident 96's fall intervention was to ensure call light was within reach while in bed. CNA 3 stated Resident 96 does not consistently use the call light to ask for assistance. CNA 3 stated Resident 96 was independent with transfers, could walk to the bathroom and use the toilet by herself. During an interview on [DATE] 10:03 am with LVN 2, LVN 2 stated Resident 96 had an unwitnessed fall [DATE] at 2:15 p.m. and LVN 2 was the nurse in charge of Resident 96. LVN2 stated Resident 96 was found on the floor sitting between her bed and wheelchair facing the bathroom. LVN 2 stated Resident 96 reported she wanted to go to the bathroom and did not say how she fell. LVN 2 stated a discoloration on right side of the forehead was observed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Resident 96 stated she hit her head. LVN 2 stated the physician was notified and Resident 96 was sent out to acute care hospital for further evaluation. LVN 2 stated Resident 96 previous fall care plan was not effective. LVN 2 stated Resident 96's new fall intervention added bowel and bladder every two hours to check if Resident 96 needed to use the restroom and Resident 96 was enrolled in the falling star program. LVN 2 stated the Falling Star program was a Facility Fall Safety program which enrolled residents who had two or more falls within the previous 30 days. LVN 2 stated on [DATE] was her first day working in the facility and was not told by the outgoing nurse Resident 96 was a high fall risk. LVN 2 stated Resident 96's falls could have been prevented if nursing staff performed frequent checks and provided bowel and bladder every two hours to Resident 96 but did not. LVN 2 stated Resident 96 was readmitted to the facility on [DATE]. During an interview on [DATE] at 11:02 a.m. with CNA 8, CNA 8 stated she was assigned to care for Resident 96 on [DATE] when Resident 96 had an unwitnessed fall. CNA 8 stated Resident 96 was able to self-propelled in her wheelchair, independent with transfer and able to ambulate to the toilet. CNA 8 stated Resident 96 would get out of bed without using the call light to ask for assistance. During an interview on [DATE] at 1:12 p.m. with CNA 7, CNA 7 stated Resident 96 had an unwitnessed fall on [DATE] at 2:15 p.m. during morning and afternoon shift change. CNA 7 stated both morning and afternoon CNA staff were to report to the Charge nurse during a shift change. CNA 7 stated she was not the CNA in charge of resident 96 but CNA 7 had established rapport with Resident 96 and was familiar with her bedside care. CNA 7 stated after the shift report was done, she went to check on Resident 96 and said goodbye before leaving and found Resident 96 sitting on the floor inside her room. CNA 7 stated she immediately notified the charge nurse, who assessed Resident 96. CNA 7 stated Resident 96 was assisted back to bed. CNA 7 stated Resident 96 is alert, pleasant and can keep a conversation. CNA 7 stated Resident 96 was on supervision for transfers and toileting and had to be observed and provided with verbal guidance because Resident 96 was able to self-transfer from bed to a wheelchair and perform toileting independently. CNA 7 stated Resident 96 liked to do things on her own. CNA 7 stated Resident 96's fall may have been preventable with supervision and continuous monitoring for her safety. During an interview on [DATE] at 2:47 p.m. with LVN 7, LVN 7 stated he was the Charge Nurse assigned to Resident 96 when Resident 96 had an unwitnessed fall on [DATE] at 9:30 p.m. LVN 7 stated Resident 96 was found sitting on the floor beside her bed barefoot without a nonskid sock. LVN 7 stated upon interviewing Resident 96 reported Resident 96 was trying to reach her drawer to get something when her feet slipped out from under her. LVN 7 stated Resident 96 required supervision with transfers and toileting and did not call for assistance. LVN 7 stated Resident 96 was able to transfer from the bed to the wheelchair and used the wheelchair to self-propel around her room and the facility. LVN 7 stated Resident 96's Nursing-Fall Risk Observation/Assessment (is an evaluation used by healthcare professionals to identify a resident's likelihood of falling - low, moderate, and high-risk falls) was assessed as a moderate fall risk. LVN 7 stated fall precaution interventions included keeping the bed in a low position, ensuring the call light and belongings were within reach and ensuring proper footwear was worn. LVN 7 stated Resident 96 does not use the call light for help or assistance when transferring from bed to wheelchair, from a wheelchair back to bed, or when going to the toilet, because of her preference for independence. LVN 7 stated Resident 96's fall could have been prevented if resident 96 had worn nonskid socks and called for help. LVN 7 stated Resident 96's care plan was updated to include wearing nonskid socks when out of bed to prevent slipping. During a review of the facility's policy and procedure (P&P) titled Falls, dated 12/2007, the P&P indicated, . Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try prevent. from falling.minimize (continued on next page)		

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

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications from falling. If underlying causes cannot be readily identified or corrected, staff will try various interventions. until falling is reduced or stopped. If the resident continues to fall, staff re-evaluate the situation and whether it is appropriate to continue or change current interventions.		

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to ensure the daily nurse staffing information publicly posted for a facility with a census of 89 residents reflected the actual hours worked by nursing staff. This failure had the potential to provide residents, resident representatives, visitors and the public with inaccurate information regarding the facilities' daily nurse staffing levels, limiting their ability to make informed decisions based on the facilities' actual staffing. Findings: During an observation on 7/16/26 at 2:49 p.m. the facilities publicly posted staffing document titled Staffing Information 2026 was reviewed. The posting reflected staffing information for Thursday, July 16, 2026, including a census of 89 residents and staffing hours by shift. The posting did not indicate the staffing hours reflected actual hours worked. During a concurrent interview and review of the facilities Staffing Information 2026 sheet, dated 7/16/26 and Appendix PP Tag F732, dated 2/3/23, on 7/16/26 at 3:17p.m. with the Director of Staff Development (DSD), the DSD stated she prepared and posted the daily staffing sheet using the monthly certified nursing assistant (CNA) and licensed vocational nurse (LVN) schedules and the facility census. The DSD stated the staffing sheet was posted the evening before for the following day and updated only if scheduled staffing changes occurred. When asked whether the publicly posted staffing sheet reflected the days actual hours worked, the DSD stated the posting reflected projected staffing and acknowledged the information could change throughout the day. The DSD stated actual hours worked were maintained by the human resources/payroll department after staff completed their shifts and were not reflected on the publicly posted staffing sheet. The DSD further stated the facility had always posted staffing information using this process. After review of Appendix PP Tag F732, the DSD verbalized understanding the regulation requires the facility to publicly post actual hours worked rather than projected staffing hours. During a concurrent interview and review of the facilities Staffing Information 2026 sheet, dated 7/16/26 and Appendix PP Tag F732, dated 2/3/23, on 7/16/26 at 3:17p.m. with the Director of Nursing (DON), the DON stated the facility had been posting projected staffing hours because staff believed that was the required process and the federal requirement to post actual hours worked came as a surprise. The DON stated responsibility for ensuring the daily nurse staffing information was posted in accordance with federal requirements belonged to the DSD. The DON acknowledged the federal requirement was to publicly post actual hours worked and stated accurate staffing information was important for residents, visitors and the public to know the facility had sufficient staff to safely care for residents. Following review of Appendix PP Tag F732, the DON verbalized understanding the facility was required to publicly post actual hours worked rather than projected staffing hours. During a review of facilities policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers dated August 2022, the P&P indicated, The information recorded on the form shall include the following: g. the actual time worked during that shift for each category and type of nursing staff.		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. Based on observation, interview and record review, the facility failed to ensure a psychiatric consultation recommendation was reviewed, communicated to the interdisciplinary team (IDT) and the attending physician and appropriately followed up for one of eight sampled residents (Resident 56). This failure had the potential to delay the evaluation and implementation of a recommended intervention intended to address the residents emotional and psychosocial needs and could have affected the facilities ability to ensure timely behavioral health services. Findings: During an interview on 7/14/26 at 9:10 a.m. with Resident 56 in her room, Resident 56 disclosed her husband of thirty-six years had passed away a few months prior. Resident 56 became tearful while discussing her loss. Resident 56 stated she had not been seen by psychiatric services while residing at the facility. During a review of Resident 56's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 7/16/26 , the AR indicated Resident 56 had the following diagnoses: depression (a medical condition that caused a person to feel sad, hopeless, or lose interest in things they usually enjoyed for a long time) and anxiety (a medical condition that caused a person to feel excessive worry, fear or nervousness, even when there was little or no danger). During a review of Resident 56's Minimum Data Set (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 7/2/26, the MDS indicated a Brief Interview for Mental Status (BIMS- an assessment of cognitive function) score of fifteen (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 56 had no cognitive impairment. During an interview on 7/16/26 at 10:53 a.m. with Certified Nursing Assistant (CNA) 10, CNA 10 stated Resident 56's husband had passed away while the resident was residing at the facility. CNA 10 stated she believed Resident 56 needed emotional support related to her loss and periodically checked on her, offered conversation and companionship and encouraged food and snacks when the resident had decreased appetite. CNA 10 stated Resident 56's family visited frequently and provided support. CNA 10 stated she had not observed any Resident 56 experiencing any crying episodes or any significant changes in behavior. CNA 10 stated she would report any concerns regarding Resident 56 to the nurse. During an interview on 7/16/26 at 11:00 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated she became aware of Resident 56's husband's death through resident monitoring documentation. LVN 5 stated Resident 56 was being monitored for sleep patterns, episodes of anxiety and sadness. During a concurrent interview and review of Resident 56's electronic health record on 7/16/26 at 11:15 a.m. with the Social Services Director (SSD), the SSD stated Resident 56's husband passed away on 5/4/26 while Resident 56 resided at the facility. The SSD stated she met with Resident 56 on 5/6/26 and on one additional occasion. The SSD stated a psychiatric physician assistant evaluated Resident 56 on 6/9/26 and recommended initiation of sertraline (an antidepressant [medication used to help improve a person's mood and reduce symptoms of depression] medication used to treat depression). The SSD stated Resident 56 had not received sertraline and there was no physician order for the medication. The SSD stated the psychiatric consultation note did not indicate Resident 56 declined the recommendation and Resident 56 had never received sertraline. The SSD stated an IDT meeting was not conducted to review the psychiatric consultation recommendations related to Resident 56's husbands' death. The SSD stated she was unaware Resident 56 wanted someone to talk to regarding her loss. The SSD stated Resident 56 was encouraged to participate in activities of her choice and received frequent family visits. The SSD stated she believed psychiatric consultation recommendations should have been followed up (continued on next page)		

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regarding the psychiatric recommendation to initiate sertraline being missed. Resident 56 was seen for a psychiatric follow up and psychotropic medication review. The consultation indicated Resident 56 reported her spouse had recently passed away and endorsed feeling sad. The assessment concluded a diagnosis of depression and anxiety disorder. The treatment plan documented start sertraline 50 milligrams (mg-a unit of measurement used to measure a very small amount of medication) tablet once daily, continue behavioral monitoring by staff, and continue routine psychiatric follow-up, and indicated no criteria for psychiatric hospitalization at the time. The attached medication orders included sertraline 50 mg by mouth once daily for depression related to verbalization of sadness and alprazolam 0.25 mg by mouth three times daily for anxiety related to repetitive anxious health concerns. During a review of Resident 56's Medication Review Report, dated 7/16/26, the Medication Review Report indicated, no active orders for sertraline. During an interview on 7/17/26 at 12:10 p.m. with the Director of Nursing (DON), the DON stated that the psychiatric provider communicated consultation findings and recommendations to the SSD, who was responsible for presenting the recommendations to the IDT for review and discussion. The DON stated the recommendation documented in the psychiatric consultation dated 6/9/26 to consider starting sertraline was not brought to the IDT for discussion and was not communicated to the attending physician. The DON stated there was no tracking process beyond the SSD receiving the consultation and believed the psychiatric provider's recommendation may not have been communicated because an order was not sent. The DON stated psychiatric recommendations were intended to support residents emotional and psychological well-being and quality of life. When asked about the potential impact of not following up on a psychiatric recommendation, the DON stated it could have affected the resident's day to day functioning, but noted the SSD had followed up with Resident 56 after the episode of crying. During a review of the facility's policy and procedure (P&P) titled, Behavioral Assessment, Intervention, and Monitoring, dated 3/2015, the P&P indicated, the interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress and potential safety risk to the resident, and develop a plan of care accordingly.if the resident is being treated for altered behavior or mood, the IDT will seek and document any improvements or worsening in the individual's behavior, mood and function.During a review of the facility's policy and procedure (P&P) titled, Depression-Clinical Protocol, dated 9/2012, the P&P indicated, with consultative support as needed, the physician will order appropriate non-pharmacological and pharmacological interventions, based on the preceding assessments.the staff and physician will monitor the residents response to treatment for depression and will document approaches, timetables, and goals of treatment in the interdisciplinary care plan and progress notes.During a review of the facility's policy and procedure (P&P) titled, Behavioral Health Services, dated 2/2019, the P&P indicated, behavioral health services are provided to residents as needed as part of the interdisciplinary, person centered approach to care.residents who exhibit signs of emotional/psychosocial distress receive services and support that address their individual needs and goals for care.During a review of the facility's policy and procedure (P&P) titled, Social Services, dated 9/2021, the P&P indicated, the director of social services is a qualified social worker and is responsible for b. providing for the social and emotional needs of the resident and family.the facility staff is able to identify and address factors that have potentially negative effect on psychosocial functioning of a resident, for example e. difficulty coping with change or loss, g. behavioral problems (confusion, anxiety, loneliness, depressed mood, anger, fear, wandering, psychotic episodes), i. bereavement or unresolved grief.During a review of the facility's Social Services Director Job Description, dated 12/2025, the document indicated provide medically related social services so that the highest practicable physical, mental and psychosocial wellbeing of each resident is attained or maintained.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation and interview, the facility failed to account for and periodically reconcile controlled drugs (medications or chemicals that the government tightly regulates because they carry a risk of being misused, causing addiction, or leading to dependence) when the facility was unable to provide documentation indicating periodic reconciliation of controlled drugs was being completed. This failure had the potential to result in controlled drug discrepancies and medication diversion (the illegal transfer, theft, or misuse of prescription medications from their intended path). During a concurrent observation and interview on 7/16/26 at 8:28 a.m. with the Director of Nursing (DON), in her office, the DON was observed with the Consultant Pharmacist (CP) actively destroying controlled medications. The DON stated controlled medications for destruction were kept in the DON's office in a locked container. During an interview on 7/16/26 at 8:45 a.m. with the DON, the DON stated there was no single process for periodically reconciling medications but rather many processes were in place such as keeping count in the narcotic book and verifying the count against the medication cards at the beginning of the shift and before the leave of shift to ensure the narcotic count was correct. The DON stated another process for verification of controlled drugs included if medications were needing to be refilled and pharmacy was unable to refill the medication because it was too soon to be refilled, that would raise concern and cause an investigation into those circumstances. The DON stated she did not have a process to reconcile controlled medications periodically. The DON acknowledged those processes were not adequate for periodic reconciliation and accounting of all controlled drugs and stated it was important to have a process to reconcile controlled medications periodically to help prevent diversion. During an interview on 7/16/26 at 8:47 a.m. with the CP, the CP stated she was aware of the State Operations Manual (SOM- is an official federal guidebook that provides rules, instructions, and policies for state inspectors to check if healthcare facilities follow safety and health laws) mandate to have a process in place to reconcile medications and the need for periodic review to reconcile narcotic (potent, often addictive drugs that dull senses, relieve severe pain, and induce sleep or stupor) medications. CP stated it was important to have a process in place to periodically reconcile narcotics and account for all controlled medications so that nurses could not divert the medications.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was eight percent. There were 25 opportunities for errors and two medication errors occurred for two of five sampled residents (Resident 6 and Resident 12) when: 1. Licensed Vocational Nurse (LVN) 5 administered 8 units of Novolin R (a short-acting insulin used to decrease blood sugar) instead of the prescribed Humulin R (a short-acting insulin) to Resident 6. 2. LVN 5 administered 8 units of Novolin R instead of the prescribed Humulin R to Resident 12. This failure resulted in two medication errors and had the potential to result in dosing mistakes from concentration differences, unexpected blood sugar fluctuations, and possible allergic reactions. 1. During a review of Resident 6'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 7/16/26, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a chronic condition where the body cannot properly process sugar for energy, causing it to build up in the bloodstream) with diabetic neuropathy (prolonged, high blood sugar from diabetes has caused structural and functional damage to the body's nerves), urinary tract infection, cerebral infarction (stroke), hyperlipidemia (too much cholesterol and fats circulating in the blood). During a concurrent observation and interview on 7/15/26 at 10:53 a.m. with LVN 5, in Resident 6's room, LVN 5 was observed checking Resident 6's blood sugar. LVN 5 stated Resident 6's blood sugar was 291. LVN 5 administered 8 units (unit of measure) of Novolin R. During a review of the facility document titled, Resident: [Resident 6's name] Order Details, dated 12/22/25, the document indicated Resident 6 had current orders for Humulin R injection Solution 100 unit/ML (unit of measure) inject as per sliding scale (sliding scale provided- a personalized chart that tells the nursing staff how much short-acting insulin to inject) subcutaneously (under the skin) three times a day for type 2 diabetes mellitus Fingerstick Blood Sugar (FSBS) check with insulin sliding scale coverage at AC (before meals) and HS (at bedtime). During a review of the facility document titled, *PACS-MEDICATION ADMINISTRATION RECORD, dated July 2026 the document indicated, .HumuLIN R injection Solution 100 UNIT/ML. subcutaneously three times a day for Type 2 DIABETES MELLITUS [DM]. During a concurrent interview and record review on 7/15/26 at 1:32 p.m. with LVN 5, Resident 6's current insulin orders were reviewed. LVN 5 stated Resident 6's current insulin orders included Lantus 34 units one time at 9 p.m. and Humulin R TID (three times a day)-breakfast lunch dinner and HS (at bedtime). LVN 5 stated she had administered 8 units of Novolin R to Resident 6 LVN 5 stated Resident 6's insulin order did not match the insulin medication that she had, on hand. LVN 5 stated the insulin on hand and administered, should match the insulin order prescribed because if staff administered the wrong insulin, it could severely hurt somebody. 2. During a review of Resident 12's AR dated 7/16/26, the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus, urinary tract infection, hyperlipidemia, chronic kidney disease (when the kidneys are damaged and slowly lose the ability to properly filter waste and extra fluid from the blood). During a concurrent observation and interview on 7/15/26 at 11:08 a.m. with LVN 5, in Resident 12's room, LVN 5 was observed checking Resident 12's blood sugar. LVN 5 stated Resident 12's blood sugar was 256. LVN 5 administered 8 units of Novolin R to Resident 12. During a review of the facility document titled, Resident: [Resident 12's name] Order Details, dated 6/17/21, the document indicated Resident 12 had current orders for Humulin R Solution inject as per sliding (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scale (sliding scale provided) subcutaneously before meals and at bedtime. During a review of the facility document titled, *PACS-MEDICATION ADMINISTRATION RECORD, dated July 2026 the document indicated, .HumuLIN R Solution (Insulin Regular Human).subcutaneously before meals and at bedtime for Type 2 DM. During a concurrent interview and record review on 7/15/26 at 1:40 p.m. with LVN 5, Resident 12's current insulin orders were reviewed. LVN 5 stated Resident 12's current insulin orders included Glargine (Lantus- a long-acting insulin) one time a day at 8:00 p.m.-15 units and Humulin R TID-breakfast, lunch, dinner and HS. LVN 5 stated she administered 8 units of Novolin R to Resident 12 and acknowledged Resident 12's current short acting insulin order did not match the insulin she had on hand. LVN 5 stated insulin on hand and administered should match the insulin order prescribed, because giving the wrong insulin could severely hurt someone. During an interview on 7/16/26 at 9:01 a.m. with the Director of Nursing (DON), the DON stated her expectations were that the insulin on hand and available at the facility for administration match the prescriber's orders. The DON stated nurses should have identified the medication error; the nurse receiving the medication should have verified the medication upon delivery and should not have accepted the insulin medication, and instead returned the drug to pharmacy. The DON stated it was the nurses' responsibility that prior to administering medications they completed checks that included verifying the right patient, the right medication, the right dosage etc. before administering that medication. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated April 2019, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.		