STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056338	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morning Star Post Acute	111 Barstow Ave. Clovis, CA 93612

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow professional standards practice and the facility's policy and procedure for one of four sampled residents (Resident 1) when Resident 1 was not administered medications as ordered by the physician on 5/23/25. This failure had the potential for Resident 1 to experienced worsening chronic conditions, health deterioration, re-hospitalization and or death. Findings: During a concurrent interview and record review on 6/12/25 at 3:33 p.m. with Licensed Vocational Nurse (LVN 2) at the nursing station, Resident 1's Medication Administration Record (MAR) and Progress Notes dated 5/23/25 were reviewed. The MAR, dated 5/23/25 at 9 a.m. indicated Resident 1 did not receive Allopurinol for gout (a type of inflammatory arthritis that causes pain and swelling in your joints, usually as flares that last for a week or two, and then resolve) , Duloxetine for depression (feelings of sadness don't go away and can get in the way of your everyday life), Empagliflozin for Diabetes Mellitus Type 2 Mellitus (DM2- a condition where your body does not use a hormone that helps move sugar from your blood into your cells for energy properly), Linagliptin for DM2, and Rifaximin for cirrhosis (a type of liver damage where healthy cells are replaced by scar tissue) due to code 11 which indicated the medication was not available. The Progress Notes (PN) dated 5/23/25 indicated the Licensed Nurse (LN) did not document the provider was notified of Resident 1's missed medication dose. LVN 2 stated when a medication is unavailable and cannot be administered, the nurse was required to notify the prescribing physician so appropriate actions can be taken, such as ordering a substitute medication or directing staff to monitor Resident 1 for change of conditions. LVN 2 stated this failure could place Resident 1 at risk for worsening of chronic medical condition, overall health decline, increased chances of rehospitalization, or even death. LVN 2 stated the licensed nurse did not follow facility's policies and procedure for missed medication. During a review of Resident 1's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/13/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses: encephalopathy (a disturbance of brain function that causes confusion, memory loss and coma in severe cases), DM2, other liver cirrhosis, chronic gout, anxiety disorder (differ from normal feelings of nervousness or anxiousness and involve excessive fear or anxiety), and recurrent Major Depressive Disorder. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056338	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Morning Star Post Acute	111 Barstow Ave. Clovis, CA 93612

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 1's Minimum Data Set assessment tool (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 5/22/25, the MDS indicated a Brief Interview for Metal Status (BIMS- an assessment of cognitive function (a mental process such as memory, language, or problem-solving that helps someone to think and process information) score of 14 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 1 had no cognitive impairment. During a concurrent interview and record review on 6/12/25 at 4:57 p.m. with the Director of Staff Development (DSD) in the DSD's office, Resident 1's MAR and Progress Notes dated 5/23/25 were reviewed. The MAR, dated 5/23/25 at 9 a.m. indicated Resident 1 did not receive Allopurinol for gout, Duloxetine for depression, Empagliflozin for Diabetes Mellitus Type 2 Mellitus, Linagliptin for DM2, and Rifaximin for cirrhosis due to code 11 which indicated the medication was not available. The PN dated 5/23/25 indicated the LN did not document the provider was notified of Resident 1's missed medication dose. The DSD stated the LN should have notified the physician of the missed dose and documented the communication with the physician but did not. The DSD stated when a medication dose was missed and the provider was not informed, Resident 1 might not maintain the correct therapeutic drug level (the specific amount or concentration of a drug or medicine that needs to be present in a person's bloodstream to produce the desired positive effect). The DSD stated this could lead for Resident 1's chronic health condition becoming worse. The DSD stated the LN did not follow the facility's policies and procedure for missed medication dose. During a review of the facility's policy and procedure titled, Administering Medications, revised 12/2012, the policy indicated 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed time . During a review of the facility's P&P titled, IF11: Unavailable Medications not dated, the P&P indicated B. Nursing staff shall: 1) Notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. a. If the facility nurse is unable to obtain a response from the attending physician, the nurse should notify the nursing supervisor and contact the Facility Medical Director for orders and/or direction. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order. During a review of the National Library of Medicine Professional Referenced titled, Nursing Rights of Medication Administration, published 4/4/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK560654/) the reference indicated, .Right time-administering medications at a time that was intended by the prescriber .A guiding principle of this 'right' is that medications should be prescribed as closely to the time as possible, and nurses should not deviate from this time by more than half an hour to avoid consequences such as altering bioavailability of other chemical mechanisms .