

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056338	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/10/2024
NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure residents were treated with dignity and respect for nine of 13 sampled residents (Residents' 2, 4, 6, 9, 14, 21, 26, 29, 31, 34, and 106) when: 1. Licensed Vocational Nurse (LVN) 1 checked Resident 106's blood sugar level (BS-amount of sugar in the blood) without closing the privacy curtain or the door. 2. LVN 3 checked Resident 34's blood pressure (B/P-measures the pressure of circulating blood against the walls of blood vessels [channels that carry throughout the body]) and did not provide privacy. 3. LVN 3 administered medications to Residents' 2, 4, 6, 9, 21, 26, 29, 31, and 34 without closing the privacy curtain. These failures resulted in Resident 2, 4, 6, 9, 21, 26, 29, 31, 34, and 106 not provided respect and dignity during care which could potentially impact residents' well-being leading to vulnerability, decreased dignity, anxiety, stress and depression. Findings: 1. During a concurrent observation and interview on 12/5/24 at 4:35 p.m. in the East Wing cart with LVN 1, LVN 1 entered Resident 106's room. Resident 106 was lying in bed and inside the room with Resident 106 was another resident, facility staff, and a visitor. LVN 1 approached Resident 106 bedside and checked his blood sugar without closing the privacy curtain or the door, while the other resident, staff and the visitor watched LVN 1 performed the BS checked to Resident 106. LVN 1 stated he did not close the privacy curtain or the door when he checked Resident 106's blood sugar and should have. During a review of Resident 106's clinical record titled, Admission Record (AR-a medical document which contains resident's medical history, current health status, diagnosis, medications, and legal documents), dated 12/6/24, the AR indicated Resident 106 was admitted to the facility on [DATE] with diagnoses which included diabetes (high blood sugar level in the blood) and respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood). (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056338	Facility ID: 056338 If continuation sheet Page 1 of 29

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 106's Minimum Data Set (MDS- a standardized tool that collects clinical and demographic information about residents in a nursing home), assessment dated [DATE], the MDS indicated Resident 106's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 15 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 106 had no cognitive deficit. During an interview on 12/10/24 at 1:55 p.m. with Infection Preventionist (IP), the IP stated the facility practice was to provide privacy and to maintain residents' dignity during care. The IP stated LVN 1 should have closed the privacy curtain or closed the door to ensure staff and visitors walking in the hallway would not see LVN 1 checked Resident 106's blood sugar. 2. During a concurrent observation and interview on 12/5/24 at 5:39 p.m. in the west wing inside Resident 34's room, Resident 34 was sitting in her wheelchair at bedside. LVN 3 approached Resident 34 and checked Resident 34's blood pressure without closing the privacy curtain or the door, while staff and other residents was outside the room walking by the hallway. LVN 3 stated she did not provide privacy to Resident 34 when she checked the blood pressure and should have closed the privacy curtain. During a review of Resident 34's clinical record titled, AR, dated 12/6/24, the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses which included hypertension (high blood pressure) and pain. During a review of Resident 34's MDS, assessment dated [DATE], indicated Resident 34's BIMS assessment score was 13 out of 15 indicating Resident 34 had no cognitive deficit. 3. During an observation on 12/5/24 at 5:05 p.m. in the west wing hallway, LVN 3 prepared Resident 31's medications. LVN 3 walked inside Resident 31's room and Resident 31 was sitting on her wheelchair. LVN 3 proceeded to administer Resident 31's medication without closing the privacy curtain. During a review of Resident 31's clinical record titled, AR, dated 12/6/24, indicated Resident 31 was admitted to the facility on [DATE] with diagnoses which included diabetes and back pain. During a review of Resident 31's MDS, assessment dated [DATE], indicated Resident 31's BIMS assessment score was 15 out of 15 indicating Resident 34 had no cognitive deficit. During an observation on 12/5/24 at 5:15 p.m. in the west wing hallway, LVN 3 prepared Resident 21's medications. LVN 3 walked inside, and Resident 21 was lying in bed watching TV. LVN 3 proceeded to administer Resident 21's medications without closing the privacy curtain. During a review of Resident 21's clinical record titled, AR, dated 12/6/24, indicating Resident 21 was admitted to the facility on [DATE] with diagnoses which included hypertension and diabetes. During a review of Resident 21's MDS, assessment dated [DATE], indicated Resident 21's BIMS assessment score was 9 out of 15 indicating Resident 21 had moderate cognitive deficit. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/5/24 at 5:22 p.m. in the west wing hallway, LVN 3 prepared Resident 26's medications. LVN 3 walked inside Resident 26's room and Resident 26 was lying in bed watching TV. LVN 3 proceeded to administer Resident 26's medications without closing the privacy curtain. During a review of Resident 26's clinical record titled, AR, dated 12/6/24, indicated Resident 26 was admitted to the facility on [DATE] with diagnoses which included morbid obesity (more than 80 to 100 pounds above ideal body weight) and pain. During a review of Resident 26's MDS, assessment dated [DATE], indicated Resident 26's BIMS assessment score was 15 out of 15 indicating Resident 26 had no cognitive deficit. During an observation on 12/5/24 at 5:25 p.m. in the west wing hallway, LVN 3 prepared Resident 29's medication. LVN 3 walked inside Resident 29's room and administered Resident 29's medication without closing the privacy curtain. During a review of Resident 29's clinical record titled, AR, dated 12/6/24, indicated Resident 29 was admitted to the facility on [DATE] with diagnoses which included muscle weakness and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 29's MDS, assessment dated [DATE], indicated Resident 29's BIMS assessment score was 14 out of 15 indicating Resident 29 had no cognitive deficit. During an observation on 12/5/24 at 5:35 p.m. in the west wing hallway, LVN 3 prepared Resident 2's medications. LVN 3 walked inside Resident 2's room and Resident 2 was sitting up in her wheelchair at bedside eating dinner. LVN 3 proceeded to administer Resident 2's medications without closing the privacy curtain. During a review of Resident 2's clinical record titled, AR, dated 12/6/24, indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included history of falling and dementia (a progressive state of decline in mental abilities). During a review of Resident 2's MDS, assessment dated [DATE], indicated Resident 2's BIMS assessment score was 6 out of 15 indicating Resident 2 had severe cognitive deficit. During an observation on 12/5/24 at 5:39 p.m. in the west wing hallway, LVN 3 prepared Resident 34's medication. LVN 3 walked inside Resident 34's room and Resident 34 was sitting up in her wheelchair at bedside. LVN 3 administered Resident 34's medication without closing the privacy curtain. During a review of Resident 34's clinical record titled, AR, dated 12/6/24, indicated Resident 34 was admitted to the facility on [DATE] with diagnoses which included fracture (break in bone) and history of falls. During a review of Resident 34's MDS, assessment dated [DATE], indicated Resident 34's BIMS assessment score was 13 out of 15 indicating Resident 34 had no cognitive deficit. (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 12/5/24 at 6:08 p.m. in the west wing hallway, LVN 3 prepared Resident 6's medication. LVN 3 walked inside Resident 6's room and Resident 6 was lying in bed watching TV. LVN 3 proceeded to administer Resident 6's medication without closing the privacy curtain. During a review of Resident 6's clinical record titled, AR, dated 12/6/24, indicated Resident 6 was admitted to the facility on [DATE] with diagnoses which included hemiplegia (one-sided muscle weakness) and hemiparesis (partial weakness on one side of the body), and muscle weakness. During a review of Resident 6's MDS, assessment dated [DATE], indicated Resident 6's BIMS assessment score was 9 out of 15 indicating Resident 6 had moderate cognitive deficit. During an observation on 12/5/24 at 6:12 p.m. in the west wing hallway, LVN 3 prepared Resident 9's medications. LVN 3 walked inside Resident 9's room and Resident 9 was lying in bed watching TV. LVN 3 proceeded to administer Resident 9's medications without closing the privacy curtain. During a review of Resident 9's clinical record titled, AR, dated 12/6/24, indicated Resident 9 was admitted to the facility on [DATE] with diagnoses which included osteoporosis (condition in which bones become weak and brittle) and back pain. During a review of Resident 9's MDS, assessment dated [DATE], indicated Resident 9's BIMS assessment score was 14 out of 15 indicating Resident 9 had no cognitive deficit. During an interview on 12/10/24 at 2:44 p.m. with LVN 2, LVN 2 stated it was important to make sure privacy was provided to residents during medication administration. LVN 2 stated it was a dignity issue and residents rights to their privacy. LVN 2 stated, We need to provide as much privacy as we can to our residents, there are residents, staff and visitors walking by. During an interview on 12/10/24 at 3:38 p.m. with LVN 3, LVN 3 stated it was the facility practice to provide privacy when administering medications to residents. LVN 3 stated she did not close the privacy curtain and doors when she administered medications to multiple residents. LVN 3 stated she violated resident's rights to their privacy when she did not close the privacy curtain or closed the door. LVN 3 stated there are residents, staff and visitors walking by and did not need to see what was going on inside resident's room. During an interview on 12/10/24 at 5:21 p.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to provide privacy during medication administration. DON stated it was a dignity issue and violation of resident rights for not closing privacy curtains and doors. The DON stated there are other resident in the rooms and family members visiting in the room and did not need to know what is going on. During a review of facility's policy and procedure (P&P) titled, Dignity, dated 2/2021, the P&P indicated, . Residents are treated with dignity and respect at all times . Residents' private space and property are respected at all times . Staff promote, maintain and protect resident privacy, including bodily privacy during assistance . (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled Promoting/Maintaining Resident Dignity, dated 9/2/22, the P&P indicated, . All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights . Maintain resident privacy .		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to provide services which met the professional standards of practice of care for one of 13 sampled residents (Resident 14) when Licensed Vocational Nurse (LVN) 2 allowed Resident 14 to self-administer her two inhaler (a device used to give medications in the form of a spray that is breathed in through the mouth) not following their own policy and procedure of self-administration of medication. This failure had the potential for Resident 14 to not received the correct medication dose as ordered by the physician. Findings: During a review of Resident 14's clinical record titled Admission Record (AR-a medical document which contains resident's medical history, current health status, diagnosis, medications, and legal documents), dated 12/6/24, indicated Resident 14 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty breathing) and asthma (chronic lung disease that causes swelling and tightening of the muscles around the airways, making breathing difficult). During a review of Resident 14's Minimum Data Set (MDS-a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 14's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 14 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 14 had no cognitive deficit. During a review of Resident 14's Order Summary Report (OSR), dated 12/6/24m the OSR indicated, . Budesonide-Formoterol Fumarate Inhalation Aerosol [medication use to treat asthma and COPD] inhale orally two times a day . Tiotropium Bromide Monohydrate Inhalation [medication use to treat asthma and COPD] . 1 (one) puff inhale orally one time a day . During an observation on 12/6/24 at 10:40 a.m. in the east wing hallway with LVN 2, LVN 2 prepared Resident 14's medications. LVN 2 entered Resident 14's room, Resident 14 was sitting up in her wheelchair. LVN 2 proceeded to administer Resident 14's oral medications. LVN 2 proceeded and gave Resident 14 her budesonide-formoterol fumarate (prescription medication used to treat COPD) and tiotropium bromide monohydrate inhalers (prescription medication used to treat asthma). Resident 14 pumped the dose of her inhaler in her mouth. During an interview on 12/10/24 at 1:55 p.m. with Infection Preventionist (IP), the IP stated residents are allowed to self-administer medications only after completing self-administration assessment, obtained physician order and a care plan. The IP stated Resident 14 did not have an assessment, a physician's order and a care plan in place to self-administer medications. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/10/24 at 2:44 p.m. with LVN 2, LVN 2 stated he gave Resident 14 her two inhaler medications and let Resident 14 self-administer her inhalers. LVN 2 stated he should have not let Resident 14 self-administered her inhaler medications to ensure Resident 14 receives the accurate physician's order dose for inhalers. LVN 2 reviewed Resident 14's clinical record and stated Resident 14 did not have an assessment for self-administration of medication, there was no physician's order and no care plan. LVN 2 stated there should have been an assessment, physician's order, and a care plan in order for Resident 14 to self-administer medication. During an interview on 12/10/24 at 5:30 p.m. with the Director of Nursing (DON), the DON stated, Residents are assessed first before they are allowed to self-administer medications to make sure they are capable and competent to administer their own medications. The DON stated there need to have an order and a care plan when resident is allowed to self-administer medication. The DON stated Resident 14 did not have a self-administration of medication assessment, no physician's order and no care plan and should have before she was allowed to self-administer her medication. During a review of facility's policy and procedure (P&P) titled, Self-Administration of Medications, dated 2/2021, the P&P indicated, . The interdisciplinary [IDT-group of healthcare professionals from different disciplines who work together to create a patient-centered care plan] assesses each resident's cognitive and physical abilities to determine whether self-administering medication is safe and clinically appropriate for the resident . If it is deemed safe and appropriate . this is documented in the medical record and the care plan . During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, . Residents may self-administer their own medications only if the attending physician with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure residents who were unable to carry out activities of daily living (ADLs-routine tasks/activities a person perform daily to care for themselves) were provided assistance to maintain personal hygiene and grooming for one of seven sampled residents (Resident 22) when Resident 22's fingernails were long, jagged, with dark colored particles under the nails and his mouth and in between her teeth had food particles. These failures resulted in Resident 22's poor personal hygiene and had the potential to result in serious health condition. Findings: 1. During a concurrent observation and interview on 12/3/24 at 8:58 a.m. in west wing hallway, Resident 22 was lying in bed with eyes closed. Resident 22 stated she had been in the facility for a long time. Resident had long, jagged, and dirty nails with dark colored particles underneath the nails. Resident 22 stated staff would help her trim her fingernails but did not remember when the last time her fingernails were trimmed. Resident 22 had food particles in her mouth and between in her teeth. Resident 22 stated she did not remember when the last time she brushed her teeth. Resident 22 stated she would like to brush her teeth, but she needed assistance from facility staff. During a review of Resident 22's clinical record titled, Admission Record (AR-a medical document which contains resident's medical history, current health status, diagnosis, medications, and legal documents), dated 12/10/24. The AR indicated Resident 22 was admitted to the facility on [DATE] with diagnoses which included asthma (chronic lung disease that causes inflammation [swelling] and tightening of the muscles around the airways, making breathing difficult) and pain. During a review of Resident 22's Minimum Data Set (MDS-a federally mandated resident assessment tool) assessment dated [DATE]. The MDS indicated Resident 22's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 3 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 22 had severe cognitive deficit. During a concurrent observation and interview on 12/4/24 at 9:01 a.m. with Director of Staff development (DSD), the DSD stated, Her [Resident 22] fingernails are long, jagged and dirty, it should have been trimmed and cleaned. The DSD stated CNAs' were responsible to trim fingernails for non-diabetic residents on their scheduled shower days. The DSD stated Resident 22 was not diabetic and her nails should have been trimmed. The DSD stated Resident 22 had food particles in her mouth and her teeth should have been brush. The DSD stated mouth or oral care should have been provided at least twice a day, in the morning and before bedtime. The DSD stated it was a dignity issue and could lead to health problems by not providing oral care and not trimming Resident 22's fingernails. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/4/24 at 9:10 a.m. with Certified Nurse Assistant (CNA) 2, CNA 2 stated she was familiar with Resident 22's care. CNA 2 stated she did not remember cutting or trimming Resident 22's fingernails because Resident 22 sometimes refused ADL care. CNA 2 stated the facility practice was to provide nail care on shower days and as needed and each resident are scheduled for two showers a week. CNA 2 stated the practice was to provide oral or mouth care to residents twice a day. CNA 2 stated she did not remember providing oral or mouth care to Resident 22. CNA 2 stated she should have tried to provide nail care and oral care to Resident 22 and notify the licensed nurse if Resident 22 refused care. During an interview on 12/5/24 at 9:26 a.m. with CNA 1, CNA 1 stated she was familiar with Resident 22's care. CNA 1 stated Resident 22 had episodes of refusing care and gets upset at staff during care and staff usually just leave her alone. CNA 1 stated she did not remember the last time Resident 22 allowed her to trim and clean her fingernails. CNA 1 stated, Her [Resident 22's] fingernails are long, jagged, and dirty and should have been cleaned. CNA 1 stated the practice was to provide mouth care twice a day in the morning and before bedtime. CNA 1 stated Resident 22 had dentures and had tried to convinced Resident 22 into letting her clean her dentures but Resident 22 refused. CNA 1 stated she remembers Resident 22 allowed her only once to clean her dentures. CNA 1 stated it was a dignity issue which could lead to health issues when ADL was not provided to Resident 22. During an interview on 12/10/24 at 3:45 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the expectations was to provide nail care on shower days and as needed and mouth care at least twice a day. LVN 3 stated the expectation was for CNAs' to notify licensed nurses when residents refused care. LVN 3 stated Resident 2 had a history of scratching self and staff during care. LVN 3 stated oral care should have been provided to Resident 22 at least twice a day in the morning and at bedtime. LVN 3 stated, Not providing oral care could cause infection because the mouth is always moist, and bacteria loves moist places and could lead to serious health issues. During an interview on 12/10/24 at 5:35 p.m. with Director of Nursing (DON), the DON stated some residents used their hands to pick up their food and if nail care not provided regularly there are bacteria living under the nails which could potentially lead to infection. The DON stated the expectations was to make sure resident's fingernails are kept clean and short. The DON stated oral care or dental care should be provided at least twice a day in the morning and at bedtime. The DON stated staff should report to licensed nurses when residents refused care and licensed nurses could try to talk to resident to allow staff to provide ADL care. During a review of facility's policy and procedure (P&P) titled, Nail Care, dated 9/2/22, the P&P indicated, . Assessments of resident nails will be conducted to determine the resident's nail condition . Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis . Routine nail care, to include trimming and filing, will be provided on a regular schedule . Nails should be kept smooth to avoid skin injury . During a review of facility's policy and procedure (P&P) titled, Oral Care, dated 9/2/22, the P&P indicated, . It is the practice of the facility to provide oral care to residents in order to prevent and control plaque-associated oral disease .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 40641 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services on acquiring, receiving, dispensing, and administering of all drugs to meet the needs of 54 residents residing in the facility when the contracted pharmacist did not check the expiration date of the lorazepam (medication used to treat anxiety and seizure- [a burst of uncontrolled electrical activity in the brain]) medication stored in the emergency kit (E-kit-contains medications provided to residents during emergency situations). This failure placed residents at potential risk for taking expired medications which could lead to serious consequences including reduced effectiveness in treating resident's condition in an event of an emergency and potential adverse reaction. Findings: During a concurrent observation, interview and record review on 12/6/24 at 12:25 p.m. with the Director of Nursing (DON) in the medication room, the refrigerator e-Kit which contained two vials of lorazepam 2MG/ML (milligram-unit of measurement/milliliter-unit of measurement), with an expiration date of 11/30/24. The DON stated The E-kit should have been replaced before or on the date the medication [lorazepam] expired. The DON stated a resident could have needed the medication after it expired and there was no medication available to administer. The DON stated the pharmacist was in the facility in November 2024 and did not order a new E-kit for replacement if she noticed the lorazepam was near expiration. During an interview on 12/10/24 at 2:55 p.m. with Licensed Vocational Nurse (LVN) 2. LVN 2 stated he checked the temperature of the medication room including the refrigerator and he did not remember checking the refrigerator E-kit for the expiration dates of the medications. LVN 2 stated the pharmacist comes in the facility every month and inspects medications and expiration dates stored in the E-kit. The LVN 2 stated the pharmacist should have noticed the lorazepam was expired and should have ordered a new E-kit. During an interview on 12/10/24 at 4:50 p.m. with the DON, the DON stated the refrigerator E-kit was last opened on 10/17/24 when a resident needed a lorazepam injection. The DON stated it was the responsibility of the pharmacist to check the expiration dates of medications in the E-kit. The DON stated it was also the responsibility of the licensed nurses to check the expiration date of medications in the E-kit when checking the temperature of the refrigerator every shift and to notify the pharmacy if the E-kit needed to be replaced. During a phone interview on 12/10/24 at 5:46 p.m. with the pharmacist (PHARM), the PHARM stated, I was in the facility last month, I did a quick glance of the E-kit and checked if it was opened, and it was not, and I did not see any expired medications. The PHARM stated she would have recommended to have the E-kit replaced if there was medication nearing its expiration date. The PHARM stated there was only one vial of lorazepam in the E-kit to use during an emergency and was expired which could result in neglecting residents needs during an emergency. (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled, Automated Dispensing Machine for First Dose and Emergency Medications, dated 1/22, the P&P indicated, . The pharmacy will provide (e.g., weekly, semi-annual, monthly) inspection to evaluate . Condition and expiration dates of medications stored in the dispensing machine .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview, and record review, the facility failed to ensure medications were stored and labeled in accordance with the facility's Administering Medications, Discontinued Medications, and Storage of Medications policy and procedure when: 1. Treatment cart was left unlocked and unsupervised in front of the nursing station. This failure had the potential for residents and staff to access medicated ointments inside the cart and used which could lead to serious health condition. 2. Resident 14's two inhalers (a device used to give medications in the form of a spray that is breathed in through the mouth) did not have an open date or expiration date on the medication. 3. Resident 14's nasal spray (a devised used to give medications in the form of spray through the nose) did not have an on date or expiration date on the medication. 4. Resident 18's inhaler did not have an open date or expiration date on the medication. These failures had the potential for the medications to be given to Residents' 14 and 18 which could cause adverse reactions (harmful, unintended result caused by a medication) and decreased medication potency and could compromise therapeutic effectiveness of Resident 14 and Resident 18's inhaler and nasal spray. 5. Discontinued inhalation and anticoagulant injection medications with no label and resident name was kept in a clear plastic container placed in the corner of medication room. This failure had the potential for the medications to be administered to residents which could cause adverse reactions. Findings: 1. During initial tour on 12/3/24 at 7:34 a.m. in front of the nursing station, the treatment cart was unlocked and unsupervised. During a concurrent observation and interview on 12/3/24 at 7:42 a.m. with Licensed Vocational Nurse (LVN) 1 in front of the nursing station, LVN 1 verified treatment cart parked near the nursing station was unlocked. LVN 1 stated there are medicated ointments, and other medications inside the treatment cart. LVN 1 stated the treatment cart should have been locked to prevent residents and unauthorized staff access the medications inside the treatment cart which could result in serious health condition. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 5:30 p.m. with the Director of Nursing (DON) the DON stated her expectation was for licensed nurses to ensure the treatment cart was locked when not supervised. The DON stated residents with dementia could access cart, and ingest the medications, which could lead to adverse side effects of medications or more serious health issues. 2. During a review of Resident 14's Admission Record, (document containing resident personal information) dated 12/6/24, the AR indicated Resident 14 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD-chronic lung disease causing difficulty breathing) and asthma (a chronic lung disease that causes inflammation[swelling] and tightening of the muscles around the airways making breathing difficult). During a review of Resident 14's Minimum Data Set (MDS- a functional and cognitive abilities assessment) assessment, dated 11/13/24, indicated the Brief Interview for Mental Status (BIMS) score was 14 out of 15 (a BIMS score of 13-15 indicates cognitively intact, 8-12 indicates moderately impaired and 0-7 indicates severe impairment), which indicated Resident 14 had no cognitive impairment. During a concurrent observation and interview on 12/06/24 at 10:40 a.m. in east wing hallway, Licensed Vocational Nurse (LVN) 2 prepared Resident 14's medications including Budesonide-Formoterol Fumarate inhaler (a prescription medication used to treat COPD) which did not have open date or expiration date. LVN 2 prepared Tiotropium Bromide Monohydrate Inhaler (prescription medication used to treat asthma) with no open date or expiration date. LVN 2 stated there should have been an open dates and expiration dates for both inhalers to know when medications would expire. LVN 2 stated he did not know when medications were opened. LVN 2 stated it was important to know the date medication was opened to ensure medication was not administered past the expiration date. LVN 2 stated expired medications could be less effective and would not benefit Resident 14 who has COPD and asthma. LVN 2 stated licensed nurses are responsible in making sure to write on the box the date medications were opened. 3. During a concurrent observation and interview on 12/6/24 at 2:41 p.m. with LVN 4 in east wing cart, LVN 4 opened the medication cart and inside one of the drawers was Resident 14's Ipratropium nasal spray (prescription medication used to treat asthma) which did not have open date and expiration date. LVN 4 stated there should have been an open date and expiration date to ensure medication was not administered to Resident 14 past its expiration date. During an interview on 12/10/24 at 1:52 p.m. with Infection Preventionist (IP), the IP stated it was the responsibility of the licensed nurse opening the medication box for the first time to write down the date it was opened and the expiration date to prevent administration of expired medications to residents. The IP stated expired medication may be less effective or sometimes could be stronger which could cause serious health issues. During an interview on 12/10/24 at 3:40 p.m. with LVN 3, LVN 3 stated it was the responsibility of the licensed nurse opening the box of medication to write the date medication it was opened and the expiration date. LVN 3 stated it was important to label medication with open date and expiration date to ensure expired medications are not administered to residents. LVN 3 stated medications past its expiration dates are less effective and would not benefit residents receiving the medication. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 18's Admission Record, dated 12/10/24, the AR indicated Resident 18 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities) and wheezing (a high-pitched sound made when breathing is restricted/obstructed in the lungs). During a review of Resident 18's MDS assessment dated [DATE] indicated Resident 18's BIMS was seven of 15 which indicated Resident 18 had severe impairment in daily decision making. During a concurrent observation and interview on 12/6/24 at 3:06 p.m. with LVN 4 in the hallway next to the nursing station, LVN 4 opened east wing medication cart and inside one of the drawers was one albuterol sulfate inhaler (prescription medication used to treat asthma) which did not have an open date or expiration date. LVN 4 stated there should have been an open date and expiration date written on the packaging to ensure effectiveness of medication. LVN 4 stated the medication was only good for 30 days from the time it was opened. LVN 4 stated albuterol sulfate inhaler would not be effective after 30 days of being opened and it would not benefit Resident 18 who has asthma. 5. During a concurrent observation and interview on 12/6/24 at 12:25 p.m. with the Director of Nursing (DON) in the medication room, placed in the corner was a clear plastic bag which stored a box of enoxaparin (prescription medication used to prevent deep vein thrombosis [blood clots]) with no label and patient identifier, two unopened foil pack of ipratropium inhalation solution and one unopened foil pack of albuterol inhalation solution which did not have label and patient identifier. The DON stated the medication labels should not have been removed and medications placed in the clear plastic container for destruction. The DON stated the medications are not facility supplies and should have been labeled specific to residents. The DON stated it was not acceptable because there was a potential to be administered to other residents. The DON stated she was responsible in destroying non-narcotic medications at least once a week with another licensed nurse. During an interview on 12/10/24 at 1:46 p.m. with the IP, the IP stated expired and discontinued medications should be pulled out from the medication cart and placed in the clear plastic container in the medication room for destruction. The IP stated medication label with patient information should not be removed from the box of the medication to prevent administration of medication to other residents. During an interview on 12/10/24 at 4:46 p.m. with the DON, the DON stated her expectation was for licensed nurses to write the date medication was opened and the expiration date to ensure expired medications are not administered to residents. The DON stated expired or discontinued medication should be pulled out from the medication cart right away and placed in the plastic container in the medication room for destruction and labels should not be removed. The DON stated there was a potential risk for expired or discontinued medications could be administered to residents when not removed from the medication cart which could lead to adverse reaction. During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/19, the P&P indicated, . The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container . During administration of medications, the medication cart is kept closed and locked when out of sight . the cart must be clearly visible . (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's P&P titled, Discontinued Medications, dated 4/07, the P&P indicated, . Discontinued medications must be destroyed or returned to the issuing pharmacy in accordance with established policies . During a review of facilities P&P titled, Storage of Medications, dated 11/2020, the P&P indicated, . Drugs and biologicals used in the facility are stored in locked compartments . Drug containers that have missing, incomplete, or incorrect labels are returned to the pharmacy for proper labeling . Compartments . containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended .		

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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. 47888 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen according to facility policy and procedures and the FDA (Food and Drug Administration-is a government agency responsible for protecting the public health) Food Code when: 1. There was brown, grey, and black debris observed in several areas in the kitchen, including one ventilator fan in the milk refrigerator, two vents above the dishwasher area, one vent in front of the milk refrigerator and one vent in front of the food warming table. 2. There was black and brown debris found on the cabinet shelves next to the stored clean bowls. 3. There was brown debris on every shelf inside of one food cart. 4. There was brown debris on top of the toaster and brown particles found inside the toaster. 5. There was a beef roast inside a plastic bag covered in ice stored in the meat freezer. These failures had potential for cross contamination (when harmful bacteria accidentally moves from one food item to another) and exposure of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) of residents' food resulting in food-borne illness (stomach illness acquired from ingesting contaminated food) to a population of 53 of 54 residents who received food from the kitchen. Findings: 1. During a concurrent observation and interview on 12/3/24 at 7:40 a.m., with the Dietary Manager (DM), in the kitchen, the ventilator fan in the milk refrigerator had black debris. The milk and juice ready for resident consumption were stored directly underneath the fan. The DM stated the black debris in the ventilator fan should have been cleaned. The DM stated the drinks stored underneath the ventilator fan were ready to go [ready for residents' consumption] to residents. During a concurrent observation and interview on 12/3/24 at 8:13 a.m., with the DM, in the kitchen, two vents on the ceiling above the dishwasher, one above the food warmer and one in front of the milk refrigerator had brown, grey and black debris. The DM stated the two vents were dirty and needed to be cleaned. During an interview on 12/5/24 at 2:37 p.m., with the Infection Preventionist (IP), the IP stated the vents and fan in the milk refrigerator were dirty and needed to be cleaned. The IP stated the black stuff, I don't know what that is. The IP stated cross contamination (when harmful bacteria accidentally move from one food item to another) could have occurred. The IP stated potential outcomes for residents would be gastrointestinal (the organs and systems that process food and liquids in the body) infections with hospitalization s up to death. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 3:45 p.m., with the DM, the DM stated the expectation would be for the vents and fans to be clean with no debris. The DM stated there was potential for cross contamination to have occurred to residents. The DM stated residents could get sick. The DM stated the facilities Sanitation policy was not followed. During an interview on 12/5/24 at 4:35 p.m., with the Maintenance Director (MD) the MD stated he was responsible for cleaning the vents and the vents should have been clean and spotless and were not. The MD stated residents could have been affected by airborne pathogens (bacteria floating in the air which attach to surfaces of products or fall down to the ground) and dust from the debris on the vents. The MD stated the Sanitation policy and procedure was not followed. During an interview on 12/10/24 at 9:20 a.m., with the Director of Staff Development (DSD)/IP, the DSD stated the expectation was for the vents and fan to be cleaned and replaced if needed. The DSD stated residents could get sick from cross contamination. The DSD stated the policy and procedure Sanitation was not followed by kitchen and maintenance staff. During an interview on 12/10/24 at 10:17 a.m., with the Registered Dietician (RD), the RD stated the expectation was for the vents and fan to be cleaned every month and as needed, but they didn't appear to be. The RD stated cross contamination could have occurred to residents. The RD stated dust or particles could have fell in food and caused a food-borne illness. The RD stated food-borne illness could cause sickness, weight loss and death. The RD stated staff did not follow the facility kitchen Sanitation policy and procedure. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces, the FDA Food Code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-27B Contact Surfaces, and Utensils, the FDA Food Code indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, POLICY: The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. PROCEDURE: . 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams cracks and chipped areas . 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents . which will be cleaned by maintenance staff . 2. During a concurrent observation and interview on 12/3/24 at 8:10 a.m., with the DM, in the kitchen, two cabinet shelves had black and brown debris. and next to the shelves were stored clean bowls. The DM stated, the cabinet shelves should be cleaned to prevent cross contamination. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 2:37 p.m., with the IP, the IP stated the black and brown debris on the shelves next to the stored clean bowls looked like rust. The IP stated the shelves with black and brown debris should have been replaced. The IP stated cross contamination could have occurred. The IP stated potential outcomes for residents would be gastrointestinal infections with hospitalization s up to death. During an interview on 12/10/24 at 9:20 a.m., with the DSD/IP, the DSD stated the shelving and cabinet with black and brown debris should have been cleaned and/or replaced. The DSD stated residents could get sick from cross contamination. The DSD stated the Sanitation policy and procedure was not followed by kitchen staff. During an interview on 12/10/24 at 10:17 a.m., with the RD, the RD stated the black and brown debris on the shelves looked like corrosion and was not in good repair. The RD stated cross contamination could have occurred to residents. The RD stated particles could fall from the shelves and get into the food which could cause food-borne illness. The RD stated food-borne illness could result in resident sickness, weight loss and death. The RD stated staff did not follow the facility kitchen Sanitation policy and procedure. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces, the FDA Food Code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-27B Contact Surfaces, and Utensils, the FDA Food Code indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, POLICY: The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. PROCEDURE: . 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams cracks and chipped areas . 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents . which will be cleaned by maintenance staff . 3. During a concurrent observation and interview on 12/3/24 at 8:15 a.m., with the DM, in the kitchen, the food cart shelves had brown debris. The DM stated the tray cart should have been cleaned and was not. The DM stated, I don't know what that is [brown debris in the food cart shelves]. The DM stated prepared resident food trays were stored inside the cart and cross contamination could have occurred. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/5/24 at 2:37 p.m., with the IP, the IP stated prepared resident food were stored inside food carts and cross contamination could have occurred. The IP stated the food cart needed to be replaced. The IP stated potential outcomes for residents would be gastrointestinal infections with hospitalization s up to death. The IP stated kitchen Sanitation policy and procedure was not followed. During an interview on 12/10/24 at 9:20 a.m., with the DSD/IP, the DSD stated the food cart needed to be cleaned and replaced. The DSD stated residents could get sick from cross contamination. The DSD stated the Sanitation policy and procedure was not followed by kitchen staff. During an interview on 12/10/24 at 10:17 a.m., with the RD, the RD stated the expectation was for the food cart to be clean and was not. The RD stated residents could have gotten food-borne illness from cross contamination which could result in resident sickness, weight loss and death. The RD stated staff did not follow the facility kitchen Sanitation policy and procedure. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-602.13 Nonfood-Contact Surfaces, the FDA Food Code indicated, The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insects, rodents, and other pests. During a review of FDA (Food and Drug Administration) Food Code 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-27B Contact Surfaces, and Utensils, the FDA Food Code indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, POLICY: The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. PROCEDURE: . 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams cracks and chipped areas . 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents . which will be cleaned by maintenance staff . 4. During a concurrent observation and interview on 12/3/24 at 7:56 a.m., with the DM, in the kitchen, brown debris was found on top of the toaster and brown particles were found inside the toaster. The DM stated the expectation for the toaster was to be clean and not have crumbs (small fragments of bread or crackers). During an interview on 12/5/24 at 2:37 p.m., with the IP, the IP stated the toaster should have been clean. The IP stated cross contamination could have occurred. The IP stated potential outcomes for residents would be gastrointestinal infections with hospitalization s up to death. The IP stated kitchen Sanitation policy and procedure was not followed. During an interview on 12/5/24 at 3:45 p.m., with the DM, the DM stated staff did not follow the kitchen policy and procedures. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/10/24 at 9:20 a.m., with the DSD/IP, the DSD stated it looked like grease on top of toaster. The DSD stated the toaster needed to be cleaned and/or replaced. The DSD stated residents could get sick from cross contamination. The DSD stated the policy and procedure Sanitation and Electrical Food Machines were not followed by kitchen staff. During an interview on 12/10/24 at 10:17 a.m., with the RD, the RD stated the expectation for the toaster was to be clean and was not. The RD stated there was corrosion (the gradual breakdown of material) on top of the toaster. The RD stated residents could have gotten a food-borne illness from cross contamination. The RD stated food-borne illness could cause resident sickness, weight loss and death. The RD stated staff did not follow the facility kitchen Sanitation and Electrical Food Machines policy and procedures. During a review of the facility's policy and procedure (P&P) titled, Electrical Food Machines, dated 2023, the P&P indicated, .Keep and maintain all food machines in good operating, sanitary condition. This includes . toasters . TOASTERS: 1. Clean daily. 2. Remove crumbs from the crumb tray daily and wipe the toaster case with a soft, damp cloth. If the case is greasy, use a non-abrasive cleaning compound to clean it . During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, POLICY: The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving and storing of food. There shall be adequate equipment for cleaning and disposal of waste and general storage. All equipment shall be maintained as necessary and kept in working order. PROCEDURE: . 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seams cracks and chipped areas . 16. The kitchen staff is responsible for all the cleaning with the exception of ceiling vents . which will be cleaned by maintenance staff . During a review of FDA (Food and Drug Administration) Food Code 2022, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-27B Contact Surfaces, and Utensils, the FDA Food Code indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic microorganisms will not be allowed to accumulate and insects and rodents will not be attracted. 5. During a concurrent observation and interview on 12/3/24 at 8:03 a.m., with the DM, in the kitchen, a beef roast inside a plastic bag covered in ice, was stored inside the meat freezer. The DM stated, it [roast beef] is not supposed to look like that. During an interview on 12/5/24 at 3:45 p.m., with the DM, the DM stated the expectation for the roast was not have any ice buildup. The DM stated bacteria could have grown on the roast and residents could get sick. During an interview on 12/10/24 at 9:20 a.m., with the DSD/IP, the DSD stated the roast had freezer burnt and the roast quality was not good and should be thrown away. The DSD stated residents could get food-borne illness from eating the roast. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Morning Star Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Barstow Ave. Clovis, CA 93612	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/10/24 at 10:17 a.m., with the RD, the RD stated the roast was not sealed properly and had freezer burn (when the meat becomes dry and tough due to moisture loss from being exposed to cold air in the freezer). The RD stated the roast should have been discarded (thrown in the trash). The RD stated the freezer burn would affect the quality of the meat and texture. The RD stated staff did not follow the facility kitchen Freezer Storage policy and procedure. During a review of the facility's policy and procedure (P&P) titled, Freezer Storage, dated 2023, the P&P indicated, .PROCEDURE: . 5. Store frozen foods in an airtight moisture-resistant wrapper such as a plastic bag or freezer paper to prevent freezer burn .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview and record review, the facility failed to maintain an effective infection prevention and control program for 54 of 54 sampled residents when: 1. The facility's Water Management Program (WMP) was not implemented since 4/8/22 to reduce the risk of Legionella (waterborne bacteria which can cause life threatening pneumonia - a lung infection) and other waterborne pathogens (germs that cause disease) in accordance with the facility's WMP. This failure placed the residents at risk for cross contamination (when harmful bacteria accidentally move from one food item to another), infection and had the potential for not identifying the risk of waterborne illnesses such as Legionella. 2. Resident 13 and Resident 30's oxygen nasal cannula (a small thin flexible tube with two prongs that fit into the nostrils and connects to an oxygen source) was on the floor. These failures placed Resident 13 and Resident 30 at risk for cross contamination which could result in infections and illness. 3. Licensed Vocational Nurse (LVN) 2 did not wipe or sanitize Resident 14's two inhaler's mouthpiece after use and prior to putting the inhalers in the box. This failure had the potential for Resident 14 to develop infection which could lead to serious health condition. Findings: 1. During a concurrent interview and record review on 12/6/24 at 2:39 p.m. with the Maintenance Director (MD), the facility policy and procedure titled WMP, dated 4/2022 was reviewed. The WMP indicated, . [Facility Name] promotes proactive steps to establish healthy, infection-free environments for their residents, staff and visitors. When residents contract Legionnaires' disease, it is often the result of exposure to inadequately managed building water systems, which can be prevented. Date of Plan Review: 4/8/22 .Water Management Team . Maintenance Director . Administrator . Director of Staff Development . Director of Nursing . Infection Prevention . The MD stated the last facility annual review of the WMP was in April 2022. The MD stated he was responsible for Legionella oversight in the facility. The MD stated he has been in his position since April 2024 and had never been part of an annual review or committee for Legionella. The MD stated a yearly review of the WMP was important to identify areas in the facility where legionella could grow, implement interventions to reduce the risk of legionnaires disease and ensure early detection. The MD stated due to a lack of WMP annual review, legionella could have been in building undetected. During an interview on 12/6/24 at 3:20 p.m., with the Infection Preventionist (IP), the IP stated she had not been part of an annual review or committee for legionella. The IP stated Legionella was a reportable communicable disease. The IP stated due to the lack of an annual review, the facility could have missed legionella in the water system. The IP stated the facility did not follow the WMP policy and procedure for Legionella. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/10/24 at 3:05 p.m. with the Administrator (ADM), the ADM stated the facility had not conducted an annual review of the WMP for Legionella since 4/2022 and he had not been part of an annual review for Legionella. The ADM stated the WMP policy and procedure for Legionella was not followed. During a review of the facility's policy and procedure (P&P) titled, Legionella Water Management Program, dated July 2017, the P&P indicated, Policy Statement: our facility is committed to the prevention, detection and control of waterborne contaminants, including Legionella . Policy Interpretation and Implementation: 1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. 2. The water management team will consist of at least the following personnel: A. The infection preventionist. B. the administrator. C. The medical director. D. The director of Maintenance and E. The director of environmental services . 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of legionnaires disease. 4. The water management program used by our facility is based on the Centers for Disease Control and Prevention . recommendations for developing a Legionella water management system. 5. The water management program includes the following elements: . 6. The Water Management Program will be reviewed at least once a year, or sooner if any of the following occur: A. the control limits are consistently not met; B. There is a major maintenance or water service change; C. There are any disease cases associated with the water system; or D. There are changes in laws, regulations, standards, or guidelines . 2. During an observation on 12/3/24 at 8:38 a.m., in Resident 13's room, Resident 13 oxygen nasal cannula was on the floor while her oxygen concentrator (a medical device that gives patient supplemental oxygen) continued to deliver oxygen. During an observation on 12/3/24 at 3:45 p.m., in Resident 30's room, Resident 30's oxygen nasal cannula was on the floor while her oxygen concentrator continued to deliver oxygen. During a concurrent observation and interview on 12/3/24 at 4 p.m., with Licensed Vocational Nurse (LVN) 2, in Resident 30's room, Resident 30's nasal cannula was on the floor while her oxygen concentrator continued to deliver oxygen therapy. LVN 2 stated the nasal cannula should not be on the floor and was an infection control issue. LVN 2 stated cross contamination (when harmful bacteria accidentally move from one food item to another) could have occurred. During a concurrent observation and interview on 12/3/24 at 4:05 p.m., with LVN 2, in Resident 13's room, Resident 13's oxygen nasal cannula was on the floor while her oxygen concentrator continued to deliver oxygen therapy. LVN 2 stated the oxygen nasal cannula should not be on the floor. LVN 2 stated the nasal cannula should be replaced. During a review of Resident 13's Face Sheet (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 13 was admitted to the facility on [DATE] with a diagnosis which included Chronic Obstructive Pulmonary Disease (COPD- a common lung disease that makes it difficult to breathe) and acute respiratory failure with hypoxia (lungs are suddenly not able to get enough oxygen into their blood, causing a lack of oxygen throughout their body). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 13's Order Listing Report (OLR), dated 12/10/24, the OLR indicated, . [Resident 13] . Order Summary: Oxygen therapy- Apply Oxygen at 4 liters (unit of measurement) per/minute as needed for COPD . Order status: Active . Created Date/By: 11/3/24 . During a review of Resident 30's Face Sheet, the face sheet indicated, Resident 30 was admitted to the facility on [DATE] with a diagnosis which included acute respiratory failure with hypoxia, asthma (a chronic lung disease that makes it difficult to breathe) and Morbid Obesity (a person's weight that exceeds an individual's desirable weight by more than 100 pounds). During a review of Resident 30's Order Listing Report (OLR), dated 12/10/24, the OLR indicated, . [Resident 30] . Order Summary: Oxygen therapy- Apply Oxygen at 4 liters (unit of measurement) per/minute as needed for acute respiratory failure . Order status: Active . Created Date/By: 11/11/24 . During an interview on 12/5/24 at 2:37 p.m., with the Infection Preventionist (IP), the IP stated the oxygen nasal cannula on the floor was unacceptable. The IP stated the potential outcome for a resident could be an infection, rehospitalization and even death. The IP stated cross contamination for Resident 13 and Resident 30 could have occurred. The IP stated staff did not follow the facility policy and procedure for Oxygen Administration. During an interview on 12/10/24 at 9:20 a.m., with the Director of Staff Development (DSD)/IP, the DSD stated the oxygen nasal cannula on the floor would have been considered infectious and needed to be thrown away and replaced. The DSD stated Resident 13 and Resident 30 had the potential for an infection and could get really sick. During an interview on 12/10/24 at 2:34 p.m. with the Director of Nursing (DON), the DON stated the expectation was for the oxygen nasal cannula to be on Resident 13 and Resident 30's nose and not on the floor. The DON stated Resident 13 and Resident 30 could have acquire bacteria and germs from cross contamination. The DON stated the facility's policy and procedure for Oxygen Administration was not followed by staff. During a review of a professional reference from https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection titled Don't Let an Oxygen Concentrator Lead to Infection, Dated 1/2020, the professional reference indicated, .2 In Use Nasal Cannula . For patients switching to portable oxygen or pro re nata home oxygen administration, nasal cannula storage can be problematic. The nasal cannula prongs often become contaminated when patients don't properly protect the cannula between uses (i.e., leaving the nasal cannula on the floor, furniture, bed linens, etc.). Then the patient puts the contaminated nasal cannula back in their nostrils and directly transfers potentially pathogenic organisms from these surfaces onto the mucous membranes inside their nasal passages, putting them at risk of developing a respiratory infection. Educate the patient on how to store the nasal cannula between uses in a manner that does not allow it to have direct contact with potentially contaminated surfaces. Either keep the in-use nasal cannula somewhere that does not allow contact with a surface or place it on a cleaned surface, inside an open clean container, or in an open plastic bag . 40641 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During a review of Resident 14's Admission Record, dated 12/6/24, the AR indicated Resident 14 was admitted to the facility on [DATE], with diagnoses which included congestive obstructive pulmonary disease [COPD- a chronic lung disease causing difficulty breathing]) and asthma [a chronic lung disease that causes inflammation and tightening of the muscles around the airways, making breathing difficult]). During concurrent observation and interview on 12/6/24 at 10:45 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared Resident 14's medications including two inhalers. Resident 14 administered her inhalers and gave inhalers back to LVN 2 and LVN 2 placed the inhalers back in the box without cleaning or sanitizing the mouth piece. LVN 2 stated he should have wiped the inhaler's mouthpiece before putting it back in the box because Resident 14 put the inhaler in her mouth and mouth have bacteria. LVN 2 stated, Moisture is a breeding ground for bacteria, and mouth is moist all the time. LVN 2 stated not sanitizing or wiping the mouth piece of the inhaler could result in respiratory infection. During an interview on 12/10/24 at 1:46 p.m. with Infection Preventionist (IP), the IP stated the practice was to clean or rinse the mouthpiece of inhalers after each use use to prevent infection. The IP stated bacteria could grow around the mouthpiece when not cleaned and transferred in the oral cavity and when inhaled goes straight in the lungs and cause infection. During an interview on 12/10/24 at 5:30 p.m. with the Director of Nursing (DON), the DON stated her expectation was to wipe the inhaler's mouthpiece after each use. The DON stated mouth have bacteria and when the inhaler's mouthpiece was placed in the mouth and not cleaned after use, bacteria could multiply and transfer to the mouth, causing infection which could lead to serious health condition. During a review of facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, . Staff follows established facility infection control procedures ([. handwashing, antiseptic technique, gloves .]) for the administration of medications, as applicable .		

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F 0911 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation and staff interview during the survey period from 12/3/24 through 12/10/24, the facility failed to ensure each bedroom accommodated no more than four residents in (room [ROOM NUMBER], room [ROOM NUMBER] and room [ROOM NUMBER]). Findings: Throughout the survey period from 12/3/24 through 12/10/24 three resident bedrooms had more than four residents in each bedroom. rooms [ROOM NUMBER] had eight residents per room. Although the bedrooms accommodated more than four residents, each room met the required needs of the residents, as well as the required square footage. The residents had a reasonable amount of privacy, and closet and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for the mobility of the residents. Wheelchairs, devices, and toilet facilities were accessible. The health and safety of the residents will not be adversely affected by the continuance of this waiver. Room Number: Number of Beds: 11 8 12 8 14 8 Recommend waiver continue in effect Don [NAME], HFES Health Facilities Evaluator Supervisor Date Request waiver continue in effect. ----- Administrator Date		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40641 Based on observation, interview and record review, the facility failed to ensure call light was within reach for three of 14 sampled (Residents' 104, 19 and 30) when: 1. Resident 104's call light was under his bed and not within his reach. 2. Resident 19 and Resident 30's call lights were on the floor and not within their reach. This failures resulted in the potential harm of Resident 19, Resident 30 and Resident 104 to not be able to call for assistance by using the call light in the event of an emergency. Findings: 1. During an observation on 12/3/24 at 7:50 a.m. in Resident 104's room, Resident 104 was sitting up in bed with breakfast tray on top of the overbed table in front of Resident 104. Resident 104 did not answer questions asked, but repeatedly requested for coffee. Call light was not within Resident 104's reach, it was on the floor under Resident 104's bed. During a review of Resident 104's clinical record titled, Admission Record, (AR-document containing resident personal information) dated 12/10/24, the AR indicated Resident 104 was admitted to the facility on [DATE] with diagnoses which included heart failure (heart doesn't pump enough blood for your body's needs), dysphagia (disorder that makes it difficulty swallowing) and end stage renal disease (kidneys stopped functioning). During a review of Resident 104's Minimum Data Set, assessment dated [DATE], indicated Resident 104's Brief Interview for Mental Status (BIMS-screening tool used in nursing home to assess cognition) assessment score was 6 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 104 had severe cognitive deficit. During a concurrent observation and interview on 12/3/24 at 8:04 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 checked for Resident 104's call light and found the call light on the floor under Resident 104's bed. LVN 5 stated Resident 104's call light should have been placed within his reach and not on the floor under the bed. LVN 5 stated, It was a resident right to have call lights within reach so they can call for assistance. During an interview on 12/4/24 at 9: 10 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated she was familiar with Resident 104 and she did not know Resident 104's call light was on the floor under the bed. CNA 2 stated the practice was to ensure call lights are placed within resident reach in order for residents to use when assistance was needed. CNA 2 stated Resident 104's call light should have been within his reach to call for assistance when needed. During an interview on 12/5/24 at 9:20 a.m. with CNA 3, CNA 3 stated the practice was to ensure call lights are placed within resident reach and not under resident's bed because it was the only way resident can call for assistance. CNA 3 stated it was everyone's responsibility to ensure call lights are within resident reach. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 3:30 p.m. with LVN 3, LVN 3 stated call lights should be placed within resident reach at all times to ensure residents can use it to call for assistance as needed. During an interview on 10/10/24 at 4:41 p.m. with the Director of Nursing (DON), the DON stated the practice was to ensure call lights are within resident reach. The DON stated call lights are placed within resident reach in order for residents to call for help when needing assistance. The DON stated staff should ensure call light are always within resident reach to avoid accidents. 47888 2. During an observation on 12/3/24 at 8:30 a.m., in Resident 19's room, Resident 19 was lying in bed watching television. Resident 19 would not answer questions asked, her call light was observed to be hung off of her bedframe and touching the ground, not within the reach of the resident. During an observation on 12/3/24 at 3:45 p.m., in Resident 30's room, Resident 30 was sitting up in bed watching television and her call light was on the floor on the right side of her bed. Resident 30 stated she did not realize the call light was on the floor. Resident 30 stated yeah I couldn't reach it down there if I needed it. Resident 30 stated I can't really move unless staff helps me. During a concurrent observation and interview on 12/3/24 at 4 p.m., with LVN 2, in Resident 30's room, Resident 30's call light was on the floor. LVN 2 stated call lights should always be within a resident's reach and it was not. LVN 2 stated this was a safety issue and something could have happened to the resident and staff not know about it. During a review of Resident 19's Admission Record, the AR indicated, Resident 19 was admitted to the facility on [DATE] with a diagnosis which included generalized muscle weakness (feeling weak in most of your muscles throughout your body) and cognitive communication deficit (the brain has difficulty processing information needed for smooth communication). During a review of Resident 19's Minimum Data Set, assessment dated [DATE], indicated Resident 19's Brief Interview for Mental Status assessment score was 6 out of 15 (0-15 scale [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit]) indicating Resident 19 had a severe cognitive deficit. During a review of Resident 30's AR, the AR indicated, Resident 30 was admitted to the facility on [DATE] with a diagnosis which included acute respiratory failure with hypoxia, asthma (a chronic lung disease that makes it difficult to breathe) and Morbid Obesity (a person's weight that exceeds an individual's desirable weight by more than 100 pounds). During a review of Resident 30's MDS, assessment dated [DATE], indicated Resident 30's BIMS assessment score was 15 out of 15 indicating Resident 30 had no cognitive deficit. During an interview on 12/3/24 at 4:15 p.m., with Certified Nursing Assistant CNA stated call lights needed to always be next to the resident. (continued on next page)		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/10/24 at 9:20 a.m., with the Director of Staff Development (DSD)/IP, the DSD stated call lights should be within the resident's reach and not on the ground. The DSD stated serious repercussions like a resident getting hurt, or a delay in care could happen from a call light not within a residents reach. The DSD stated staff did not follow the policy and procedure Answering the Call Light. During an interview on 12/10/24 at 2:34 p.m. with the DON, the DON stated call lights should be within the reach of residents and shouldn't be on bed rails or on the floor. The DON stated if a resident had an emergency, they would not have been able to grab or use it. The DON stated a resident could have been injured due to the call light not within their reach. The DON stated the policy and procedure for call lights was not followed by staff. During an interview on 12/10/24 at 11:06 a.m., with LVN 5, LVN 5 stated the expectation for call lights would to be clipped to the bed and within the reach of the residents. The LVN stated if a resident needed help, staff would not know and a resident could die. The LVN stated the policy and procedure for call lights was not followed. During a review of facility's policy and procedure (P&P) titled, Answering the Call Light, dated 4/16, the P&P indicated, . 4. Be sure that the call light is plugged in and functioning at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .		