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	02/20/2026

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

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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 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, interviews and record reviews, the facility failed to prepare and store food in accordance with professional standards for food safety for all residents who consumed meals prepared in the kitchen when a of five-pound bag of chicken with a used by date of 2/16/26 was stored in the refrigerator available for residents use. This failure placed residents at potential risk to develop gastrointestinal illness (illness that affects the digestive system [GI tact] which runs from mouth to anus) which could result in serious health conditions. During a concurrent observation and interview on 2/17/26 at 8:22 a.m. during initial tour in the kitchen with Dietary Service Manager (DSM), in the refrigerator there was a bag of chicken with prep date of 2/14/26 and used by date of 2/16/26. The DSM stated, It [chicken] was supposed to be used yesterday [2/16/26]. The DSM stated the dietary staff defrosted the chicken more than was needed During an interview on 2/19/26 at 8:28 a.m. with the DSM, the DSM stated the cook was responsible in pulling out food to thaw for use. The DSM stated refrigerators and freezers are monitored daily and checking food for the expiration dates ensuring food past the used by date are not left inside the refrigerator. The DSM stated the bag of expired chicken should have been remove from the refrigerator to avoid use. The CDM stated staff might accidentally use the expired chicken and serve to residents and somebody might get sick and we do not want that. During an interview on 2/20/26 at 8:10 a.m. with the Registered Dietitian (RD), the RD stated she was in the facility once a week and spot check refrigerators and freezers. The RD stated once meat was thawed, it was required to be served, and any portions not used was to be discarded. The RD stated it was the responsibility of all dietary staff to check daily for expired food and discard as needed. The RD stated serving food passed its used by date could cause bad taste and food borne bacteria. During a review of facility's policy and procedure (P&P) titled, Food Storage (Dry, Refrigerated, and Frozen), dated 2020, the P&P indicated, .All food items will be labeled. The label must include the name of the food and the date . Rotate products so the oldest are used first. Staff shall be instructed to use products with the earliest expiration date before those with a later expiration date. Discard food that has passed the expiration date . Follow and adhere to the guidelines regarding proper storage temperatures and maximum length of storage .

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage was stored and disposed of in a manner that prevented unsanitary conditions for all the residents in the facility when two of three outdoor dumpsters were observed with the lids open and overflowing.This failure placed residents at potential risk for exposure to pest, offensive odors, and contamination of food or medications which could compromised residents health, safety, and the overall sanitary environment of the facility. During a concurrent observation and interview on 2/18/26 at 8:15 a.m. with Dietary Service Manager (DSM), the facility's dumpster located behind the building was observed with two of the lids in the open position. One dumpster contained overflowing garbage in a plastic bag, which prevented the lid from closing securely. The DSM stated, They should have made sure to throw garbage bag in the back first for the lid to close.During an interview on 2/19/26 at 8:35 a.m. with DSM, the DSD stated the facility's dumpster was everybody's responsibility. The DSM stated leaving the dumpster open attracts vermins and causes odor. The DSM stated it was the reason why the dumpster lids should be kept shut to avoid vermins going in and contain the odor. During an interview on 2/19/26 at 9:15 a.m. with the Environmental Supervisor (EVS), the EVS stated it was his responsibility to ensure dumpster lids to remain closed at all times. The EVS stated the facility's dumpsters contained dirty briefs, foods, and other garbage which could attract pests. The EVS stated keeping garbage lids properly closed at all times help contained odors and prevent the attraction of unwanted pests. During a review of facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal, Revised date 10/17, the P&P indicated, .All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered . Garbage and refuse containing food wastes will be stored in a manner that is inaccessible to pests . Outside dumpsters provided by garbage pickup services will be kept closed and free of surrounding litter .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for two of 10 sampled residents (Residents' 5 and 10) when: 1.Resident 5's change in condition on 2/14/26, when the resident complained of a cough and subsequently received new physician orders, including cough medication, steroids (medicine used to reduce swelling and inflammation), antibiotics (medicine used to treat infections caused by bacteria [germs]) and diagnostic testing. This failure had the potential to result in inconsistent care, lack of staff awareness regarding Resident 5's change in condition and failure to monitor the effectiveness of interventions, which could have led to a decline in Resident 5's respiratory status. 2.Resident 10 did not have a care plan for a fall that happened on 2/15/26. This failure put Resident 10 at risk for additional fall and for potential injuries from the fall.1.During a review of Resident 5's admission Record (AR -a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/19/26, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses of fracture (a break or crack in a bone) of right lower leg, and muscle weakness (the muscles [a soft tissue in the body that helped a person move] did not work as strongly as they usually did). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/3/26, the MDS indicated Resident 5 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 5 was cognitively intact. During a concurrent observation and interview on 2/17/26 at 8:26a.m. with Resident 5 in his room, Resident 5 stated he had developed a productive cough beginning on 2/14/26. Resident 5 stated he had been receiving cough syrup, and throat lozenges and had undergone a chest X-ray, with results pending at the time of interview. During an interview of 2/19/26 at 9:29a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated a care plan was something she followed as a CNA. CNA 1 described it as her guide for how to care for the residents and referred to it as the resident's personal index. CNA 1 further stated new developments should be care planned because it provided her with an FYI on what to monitor and how to look out for changes in the resident's condition. During a concurrent interview and record review of Resident 5's electronic health record on 2/19/26 at 10:09 a.m. with Registered Nurse (RN)1, review of Resident 5's physician orders indicated guaifenesin (medication used to help loosen mucus in the chest) 15militers (ml- a way to measure small amounts of liquid) every 6 hours as needed for cough, dextromethorphan-benzocain (a medicine to help relieve cough and sooth a sore throat) lozenges every 4 hours as needed, Prednisone (a medicine used to reduce swelling and inflammation in the body)10 miligram (mg-a way to measure very small amounts of something, usually medicine) once daily for 5 days and azithromycin (a medication used to treat infections) 250 mg daily for 4 days. A chest x-ray revealed bilateral lower (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lung field atelectatic changes (small parts of the lungs had partially collapsed or were not fully filling with air). RN 1 stated there should have been a care plan in place at the time of the change in condition on 2/14/26, when Resident 5 complained of having a cough. RN 1 further stated care plans were important to ensure care was provided in accordance with the established plan. During an interview on 2/20/26 at 12:52p.m. with the Director of Nursing (DON), the DON stated it was her expectation that the nurse would initiate a care plan as soon as a change in condition was identified. During a record review of the facility's policy and procedure (P&P) titled, Care Plans Comprehensive Person-Centered, dated 2/2022, the P&P indicated, .assessments of residents are ongoing and care plans are revised as information about the resident and the residents' condition change.the interdisciplinary team reviews and updates the care plan when there has been a significant change in the residents condition. 2. During a concurrent observation and interview on 2/17/26 at 9:25 a.m. during initial tour in Resident 10's room, Resident 10 was observed lying in bed reading and observed with external fixator (medical device used to stabilize broken bones using metal pins or wires drilled into the bone, attached to a rigid frame or rods outside the body) on her left ankle/leg. Resident 10 stated she had a fall at home and broke her left ankle and was in the hospital where they put the metal in her leg. Resident 10 stated she had another fall in the facility recently when she slipped out of her wheelchair. Resident 10 stated she had no injury. During a review of Resident 10's AR dated 2/19/26, the AR indicated Resident 10 was admitted to the facility on [DATE] with diagnoses which included fracture (break on the bone) of left lower leg, muscle weakness and difficulty walking. During a review of Resident 10's MDS dated [DATE], the MDS assessment indicated Resident 10's BIMS score was 13 out of 15 which indicated Resident 10 had no cognitive deficit. During a concurrent interview and record review on 2/18/26 at 1:55 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 10's clinical record and stated Resident 10 had a fall at home and sustained a fracture on her left lower leg. LVN 2 stated Resident 10 was admitted to the facility with an external fixator on her left leg. LVN 2 stated Resident 10 had another fall in the facility on 2/15/26 but did not find a care plan. LVN 2 stated there should have been a care plan for the fall. LVN 2 stated care plan was important to direct staff on how to care for residents. LVN 2 stated it was the responsibility of licensed nurses to initiate care plans. During an interview on 2/19/26 at 9:35 a.m. with CNA 4, CNA 4 stated she was working on the day Resident 10 had a fall. CAN 4 stated she was on her lunch break when Resident 10 fell off her wheelchair. CAN 4 stated Resident 10 was reaching out and slipped off her wheelchair. CAN 4 stated Resident 10 requires assistance with turning and repositioning and did not complain of pain. During a concurrent interview and record review on 2/19/26 at 1:45 p.m. with Assistant Director of Nursing/Infection Preventionist (ADON/IP), Resident 10's clinical record was reviewed, and ADON/IP stated Resident 10 fell off her chair on 2/15/26 with injuries. The ADON/IP stated a change of condition report was completed on 2/15/26 but did not find a care plan. The ADON/IP stated there should have been a care plan initiated for the fall but there was none. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/20/26 at 12:15 p.m. with the DON, the DON stated Resident 10 had a recent fall in the facility on 2/15/26, a change of condition was completed but no care plan initiated. The DON stated her expectation was for the nurses to initiate a care plan after change of condition was completed. The DON stated care plan was important because It shows what we are doing to the patient, implement intervention, and solve the problem. During a review of the facility's policy and procedures (P&P) titled, Care Plans Comprehensive Person-Centered, dated 2/2022, the P&P indicated, .person-centered care plan: includes measurable objectives and timeframes; describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental and psychosocial well-being.reflects currently recognized standards of practice for problem areas and conditions.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to meet professional standards of practice for three of 10 sampled residents (Resident 12, 49 and 29) when:1. Resident 12 was administered 2.5 LPM (liter per minute-a unit of measurement for the flow rate of oxygen) of oxygen therapy (a colorless, tasteless gas essential to living organisms) without a physician's order.This failure resulted in Resident 12 receiving oxygen therapy without a physician's order which had the potential to result in shortness of breath, oxygen toxicity (lung damage that happens from breathing in too much extra oxygen therapy), and serious medical conditions.2. Resident 49 was not monitored or observed while receiving her medication through hand held nebulizer (HHN-device designed to convert liquid medication into fine mist for treating asthma and respiratory issues), nebulizer machine was turned off by a CNA when Resident 57 stated her treatment was completed and licensed nurse did not verify medication in the HHN was completedThis failure had the potential for Resident 57 to not received the whole medication dose which could lead to continued respiratory distress.3.The facility did not ensure appropriate reassessment and management of Resident 29's permacath (a special soft tube that was placed into a large vein in the chest to allow blood to be cleaned) after hemodialysis (a treatment that used a machine to clean a person's blood when their kidneys were not working properly) treatments were discontinued. This failure had the potential risk to result in improper catheter maintenance, increased risk of infection and delayed removal of an unnecessary invasive device no longer in use. 2. During a concurrent observation and interview on [DATE] at 10:15 a.m. during the initial tour of the facility in Resident 49's room, Resident 49 was observed sitting at edge of bed holding a handheld nebulizer. Resident 49 appeared appropriately dressed and stated she did not have any concerns. Resident 49 stated she also used oxygen pointing at a portable oxygen concentrator (breathing machine to help with low blood oxygen levels) at bedside, nasal cannula (flexible, plastic tube with two small prongs that fit just inside the nostrils to deliver supplemental oxygen) dated [DATE]. During a review of Resident 49's AR dated [DATE], the AR indicated Resident 49 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease , muscle weakness and heart failure (heart becomes too weak or stiff to pump blood efficiently, failing to meet the body's needs for oxygen. During a review of Resident 49's MDS assessment dated [DATE], the MDS assessment indicated Resident 10's BIMS assessment score was 15 out of 15 which indicated Resident 49 had no cognitive deficit. During a review of Resident 49's OSR dated [DATE], the OSR indicated, .Albuterol Sulfate Inhalation Nebulization Solution (2.5MG/3ML [milligram-unit of measurement/milliliter-unit of measurement] . inhale orally via nebulizer . Order Date: [DATE] . Start Date: [DATE] . During a concurrent observation and interview on [DATE] at 10:20 a.m. with CNA 5 inside Resident 5's room, CNA 5 assisted Resident 49 and turned off the nebulizer machine after Resident 49 asked for the machine to be turned off. CNA 5 stated CNAs are not allowed to turn on or off any machine residents are using, stated not part of our job description. CNA 5 stated HHN machine had medication, and CNAs are not allowed to touch resident medications. CNA 5 stated she asked Resident 49's nurse if she could turn off the nebulizer machine and was told yes by LVN 2. During an interview on [DATE] at 1:35 p.m. with LVN 2, LVN 2 stated she should have stayed with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 49 while the HHN machine was still on because there was still medication in the chamber. LVN 2 stated the practice was to stay with residents to ensure medication was completed and Resident 49 received the whole dose of medication. LVN 2 stated it was important to stay with Resident 49 while the machine was on to assess and to monitor for any possible side effects of the medication. LVN 2 stated she misunderstood CNA 5 and did not realize CNA 5 had asked if she could turn off the nebulizer machine. During an interview on [DATE] at 10:18 a.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), she stated CNAs are not allowed to turn on/off oxygen and or nebulizer machines. The DSD/IP stated, It is not part of their job description. The DSD/IP stated LVN 2 should have stayed with Resident 49 while the machine was on and after the medication was completed should have wiped down the tubing and placed it in the bag. During an interview on [DATE] at 11:50 a.m. with the DON, the DON stated her expectation was, Licensed nurses to be around the vicinity within visual when not at bedside during HHN treatment. The DON stated CNAs are not allowed to turn on/off HHN machines and oxygen. During a review of facility's policy and procedure (P&P) titled, Nebulizer, dated [DATE], the P&P indicated, .5. Administer Treatment: Instruct the resident to take slow deep breaths the mouthpiece or mask. Continue until the medication is fully nebulized (15 minutes). Monitor resident for tolerance, adverse reactions, and effectiveness . Record . Resident response (e.g., improvement in breathing, side effects) . 3. During a review of Resident 29's AR, dated [DATE], the AR indicated Resident 29 was admitted to the facility on [DATE] with diagnoses of cirrhosis of liver (a serious condition where the liver became badly scarred and damaged over time), alcohol abuse (when a person drank too much alcohol too often, in a way that hurt their body, affected behavior, or caused problems in their life) and heart failure (a condition where the heart did not pump blood as well as it should). During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29 had a BIMS score of 13, which suggested Resident 29 was cognitively intact. Resident 29's MDS indicated he received hemodialysis on admission and during stay. During a concurrent interview and observation on [DATE] at 8:36 a.m. with Resident 29 in his room, the right upper chest permacath was observed covered with a bordered gauze dressing dated [DATE]. The dressing appeared discolored with visible yellow-brown staining noted along the right and lower edges. The adhesive border was lifting and was not fully adherent to the surrounding skin. The central gauze pad appeared soiled. No active drainage was visible externally. The surrounding skin appeared intact without visible redness or swelling. Resident 29 stated he last received hemodialysis one month ago. During an interview on [DATE] at 9:29a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was aware Resident 29 had a permcath. CNA 1 stated her responsibility was to ensure the area remained clean to help prevent infection. CNA 1 stated she cleaned around the site but did not change the dressing. During a concurrent interview and review of Resident 29's electronic health record on [DATE] with Registered Nurse (RN) 1, RN 1 stated Resident 29 had previously been on hemodialysis but was no longer receiving treatments and had not received hemodialysis for some time. RN 1 stated Resident (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	29 still had his hemodialysis access. RN 1 stated staff cleaned and reinforced the permacath dressing. RN 1 stated she was not sure of the exact frequency and indicated the dressing was to be reinforced and maintained. RN 1 stated she did not see documentation of this task on the Treatment Administration Record (TAR) but staff were aware it was to be performed. RN 1 stated there should have been a care plan addressing the permcath, including care, cleaning and reinforcement of the dressing. RN 1 stated she did not know when the permacath dressing was last changed and stated she had not observed it on that day. During a concurrent interview and review of Resident 29's electronic health record with the Social Services Director (SSD), the SSD stated Resident 29 had been receiving hemodialysis at the time of admission to the facility; however, treatments had since been discontinued. The SSD stated she was unsure of the exact date hemodialysis stopped but believed it occurred during the first week of [DATE]. The SSD stated she had arranged Resident 29's hemodialysis transportation and was unsure whether discharge orders had been received from the dialysis facility. The SSD stated she was aware the facility was working on having Resident 29's permcath removed and believed the facility was waiting to hear back from a physician, although she was unsure which physician. The SSD stated Resident 29 did not have any upcoming appointments scheduled with a nephrologist (kidney doctor). The SSD stated she participated in the interdisciplinary Team (IDT- a group of professionals from different fields that coordinated patient centered care) meetings and confirmed the IDT last met on [DATE]. Review of the IDT meeting notes dated [DATE] did not include documentation addressing the discontinuation of hemodialysis treatments or a plan of care moving forward. During a review of Resident 29's Order Listing Report, dated [DATE], the Order listing Report indicated a discontinued order for hemodialysis was identified. The order had a start date of [DATE] and a revision date of [DATE]. Further review of the Order Listing Report indicated an active order for permcath site (R) chest-ensure dressing remains intact every shift; reinforce as needed. Hemodialysis center provides permcath access maintenance and dressing changes. During a review of Resident 29's Progress notes, dated month of [DATE], the Progress notes indicated Resident 29 last received hemodialysis on [DATE], at which time a post-treatment weight was obtained and the nephrologist (a doctor who specialized in treating kidney problems) recommended holding dialysis for one week. A progress note dated [DATE] indicated the nephrology group (a team of doctors and healthcare providers who specialized in treating kidney problems) contacted the facility to confirm laboratory orders for [DATE] and hemodialysis remained on hold for one week. A progress note dated [DATE] indicated laboratory results were faxed to the nephrologist, and the facility received notification from the nephrology office that Resident 29 no longer required continuation of hemodialysis treatments. During an interview on [DATE] at 12:44 p.m. with the DON, the DON stated residents were required to have current physician orders. The DON stated there should have been a new order for permcath dressing changes after hemodialysis was discontinued and appropriate orders and care should have been in place. During a review of the facility's policy and procedure (P&P) titled, Hemodialysis, dated [DATE], the P&P indicated, The facility will coordinate and collaborate with the dialysis facility to assure that: d. there is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Person-Centered, dated 2/22, the P&P indicated, .the IDT, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.assessments of residents are ongoing and care plans are revised as information about the residents and the residents condition change. During a review of the facility's policy and procedure (P&P) titled, Central Venous Catheter Care and Dressing Changes, dated 2/22, the P&P indicated, .perform site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (e.g., damp, loosened, or visibly soiled).maintain sterile dressing for all central vascular access devices.change the dressing if it becomes damp, loosened, or visibly soiled and: a. at least every 2 days for sterile gauze dressing. C. immediately if the dressing or site appear compromised.assess the integrity of securement devices with each dressing change. During a review of Resident 12's admission Record (AR -a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD-lung and airway disease that restricts breathing) , hypertensive heart disease (structural and functional heart damage caused by long-term, unmanaged high blood pressure), and heart failure (condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen). During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS indicated Resident 12 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 12 was moderately cognitively impaired. During an observation on [DATE] at 9:04 a.m., in Resident 12's room, Resident 12 was observed lying in bed with her nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) in her nose. Resident 12's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents breathe). The oxygen concentrator was observed on the left side of the bed turned on at 2.5 LPM. During a concurrent observation and interview on [DATE] at 10:47 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 12's room, Resident 12 was observed lying in bed with her nasal cannula in her nose. Resident 12's nasal cannula was observed connected to the oxygen concentrator. The oxygen concentrator was observed on the left side of the bed turned on at 2.5 LPM. LVN 2 stated she was Resident 12's nurse and was familiar with Resident 12's care needs. LVN 2 stated Resident 12 had received oxygen therapy since she was admitted to the facility. During a concurrent interview and record review on [DATE] at 10:50 a.m. with LVN 2, Resident 12's Order Summary Report (OSR), dated [DATE] was reviewed. LVN 2 stated Resident 12 did not have any active, discontinued or expired physician's orders for oxygen therapy. LVN 2 stated oxygen was a medication and required a physician's order to be administered. LVN 2 stated Resident 12 had COPD and was at risk for worsening of her condition if she received too much oxygen outside of her needs. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 2:44 p.m. with LVN 1, LVN 1 stated oxygen was a medication and required a physician's order to be administered. LVN 1 stated oxygen therapy administered without a physician's order was outside the professional scope of practice for licensed nursing staff. LVN 1 stated residents with COPD and heart failure were at increased risk of hyperoxygenation (excess oxygen) which could result in decreased drive to breathe. LVN 1 stated oxygen toxicity (damage to the lungs that happens from breathing in too much oxygen) could result in serious medical conditions. During an interview with the Director of Nursing (DON) on [DATE] at 12:22 p.m., the DON stated oxygen was a medication and required a physician's order to be administered. The DON stated if oxygen therapy was administered in an emergent situation an order was expected to be placed to reflect the use and continuing use of oxygen therapy. The DON stated Resident 12 was at risk of being over oxygenated when she was administered oxygen therapy with no physician order or oversight. The DON stated professional standards or practice, and facility policy and procedure were not followed when Resident 12 was administered 2.5 LPM of oxygen therapy with no physician order. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated [DATE], the P&P indicated, .oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.oxygen is administered under orders of a physician, except in the case of an emergency. In such case, oxygen is administered and orders for oxygen are obtained as soon as practicable. During a review of the facility's P&P titled, Physician Orders, dated [DATE], the P&P indicated, .medications should be administered only upon the signed order of a person lawfully authorized to prescribe. During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse .

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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. Based on observation, interview, and record review, the facility failed to safely and securely label and store medications ready for residents use when:1.The medication room contained four expired Fexofenadine Hydrochloride (medication used to treat allergy symptoms) 180 milligrams (mg-a unit of measurement for medication) tablet bottles, one expired Dextromethorphan HBr 20 mg Guaifenesin 400 mg (medication used to treat cough and chest congestion symptoms) bottle and two expired 8.5 fluid ounce Vashe wound solution (skin cleanser used for debriding and irrigating wounds) bottles.This failure placed residents at potential risk to receive ineffective or unsafe medications and wound care solutions, which could lead to delayed wound healing, worsening of underlying medical conditions or preventable hospitalization.2. Two over the counter medication bottles and one metered dose inhaler (MDI-small, handheld, pressurized devise used to deliver a specific, measured amount of medication directly into the lungs as a fine mist) were observed on top of Resident 32's over the bed table available for use.This failure placed Resident 32 at potential risk for medication error, experienced adverse drug reactions, or overdose which could lead to serious health condition. During a concurrent observation and interview on 2/17/26 at 11:01 a.m. with the Director of Nursing (DON), in the medication room, four unopened bottles of Fexofenadine Hydrochloride 180 mg were observed with a manufacturer expiration date of 1/2026. One unopened bottle of dextromethorphan HBr 20 mg Guaifenesin 400 mg was observed with a manufacturer expiration date of 11/2025. Two unopened 8.5 fluid ounce Vashe wound solution bottles were observed with a manufacturer expiration date of 2/2025. The DON stated all the items were expired. The DON stated the medication room should not contain any expired medications or wound treatment solutions to prevent accidental administration to residents. The DON stated licensed nursing staff reviewed expiration labels when they removed and opened medication bottles form the medication room for use. The DON stated she reviewed the medication room weekly for expired medications, supplies, and wound treatment solutions and removed expired items. The DON stated the Pharmacist Consultant (PC) reviewed the medication room monthly for expired medications and removed expired medications. During an interview on 2/19/26 at 10:44 a.m. with the Pharmacist Consultant (PC) and Pharmacist Consultant Supervisor (PCS), the PC stated expired medication needed to be removed to prevent accidental administration of expired medication to residents. The PCS stated expired medication efficacy could not be guaranteed past expiration dates. The PC stated the PC did a spot check of the medication room monthly and removed expired medications. The PC stated licensed nursing staff were expected to review expiration labels before opening and removing medications from the medication room. The PCS stated the facility was expected to adhere to all policies and procedures regarding expired medications. The PCS could not state facility policy and procedure regarding expired medications. During an interview on 2/20/26 at 12:22 p.m. with the DON, the DON stated facility policy and procedure was not followed when the medication room contained five expired bottles of Fexofenadine Hydrochloride 180 mg, one bottle of Dextromethorphan HBr 20 mg Guaifenesin 400 mg, and two bottles of Vashe wound treatment solution. The DON stated residents were at risk for accidental administration of expired medications and use of wound treatment solutions which could result in decreased potency of intended doses. During a review of the facility's manual title, California LTC Facility's Pharmacy Services and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures Manual, the policy and procedure (P&P) titled, 5.3 Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, dated 12/1/07, the P&P indicated, .facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier.medications with a manufacturer's expiration date expressed in month and year will expire on the last day of the month.facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines and other applicable law.facility personnel should inspect nursing stations storage areas for proper storage compliance on a regularly scheduled basis. During a review of the facility's P&P titled, Medication Storage, dated 9/2/22, the P&P indicated, .the pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. These medications are destroyed in accordance with facility policy. During a review of the facility's P&P titled, Medication Administration, dated 9/2/22, the P&P indicated, .identify expiration date. If expired, notify nurse manager. 2.During a concurrent observation and interview on 2/17/26 at 9:30 a.m. in Resident 32's room, Resident 32 was observed sitting up in bed applying her make-up. Resident 32 stated she was at the hospital for left leg pain, and she is still in pain. Observed two medication bottles and one MDI on top of her over the bed table. Resident 32 stated her partner brought the medications for her to use. Resident 32 stated she needed the MDI for her breathing and was using it at home prior to going to the hospital. Resident 32 stated she was not sure when she used the inhaler last, but she had used it since her partner brought it in the facility. Resident 32 stated one of the bottles contained lotion and she opened one of the medication bottles and inside was a jellylike white substance which Resident 32 claimed to be lotion. Resident 32 opened the second medication bottle and inside was white powder and stated, It is to help with my constipation. Resident 32 stated she had problems with constipation caused by pain medications she was taking in the facility. Resident 32 stated her partner did not want to bring the whole bottle of the powder medication, so he poured the powder in an empty medication bottle and crossed out over the label and written the instruction on how to take the powder. Resident 32 stated she was not sure if she told the nursing staff about the medications, but she was sure they must have seen the bottles on top of her table but did not say anything and stated, I thought it was OK. During an interview on 2/18/26 at 1:45 p.m. with Licensed Vocational Nurse (LVN)2, LVN 2 stated residents are not allowed to keep medications at bedside. LVN 2 stated she did not remember any nursing staff reporting about medications left at Resident 32's bedside table and did not remember seeing it when she administered Resident 32's medications in the morning. LVN 2 stated Resident 32's partner visits daily and must have brought it and not notified nursing staff. LVN 2 stated the practice was to educate residents and families about the facility practice of not allowing home medications brought in the facility. LVN 2 stated it was dangerous for Resident 32, she could overdose or develop allergic reactions to the medication and other residents could access the medication and take the medication themselves, not knowing if they are allergic to the medication. During an interview on 2/19/26 at 10:18 a.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated residents are not allowed to keep medications at bedside. The DSD/IP stated medications from the hospital and or home are stored in the medication room and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be given to residents upon discharge. The DSD/IP stated nursing staff should be paying attention to their surroundings. The DSD/IP stated leaving medications at bedside could cause medication overdose and adverse interaction developed when taken with other medications. During an interview on 2/19/26 at 3:15 p.m. with LVN 1, LVN 1 stated the facility does not allow families to bring medications from home for resident use while in the facility. LVN 1 stated residents are not allowed to keep medications at bedside either because other confused residents could access medications and potentially may cause allergic reactions. LVN 1 stated nursing staff had to document all medications administered to residents. During an interview on 2/20/26 at 11:44 a.m. with the DON, the DON stated the facility does not allow medications to be kept at bedside. The DON stated Resident 32 was alert and oriented, her partner visits daily and brought the medications and did not let the nurse know. The DON stated, We can not go through their belongings to check for medications. The DON stated if Resident 32 wanted to take the medication they could discuss it with her medical doctor (MD) and get an order. The DON stated keeping medications at bedside could potentially put other residents in danger because they could take the medication and develop adverse interaction with other medications leading to more serious health conditions. During a review of facility's policy and procedure (P&P) titled, Medication Storage Policy, date reviewed/revised 2/17/26, the P&P indicated, .All drugs and biologicals are stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature control. During a review of facility's P&P titled, Medications Brought to the Facility by the Resident/Family/Physician/Prescriber, Revision Date: 09/15/24, the P&P indicated, .Facility staff should not administer medications including over-the-counter medications. brought to facility by a resident, a resident's responsible party, or a resident's physician/prescriber without physician/prescriber's order.When medications from the resident's personal inventory are not ordered by the physician/prescriber, Facility staff should return the medications to the resident's family.

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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 ensure an effective infection prevention and control program was maintained for two of 15 sampled residents when:1. The facility did not ensure Resident 5 was tested for COVID-19 (Coronavirus is an infectious respiratory disease) in accordance with the facilities policy and procedure titled COVID-19, after Resident 5 developed a cough. This failure had the potential to delay identification of communicable diseases and increase the risk of transmission to other residents and staff within the facility.2. LVN 1 did not wear enhanced barrier precaution (EBP- infection control intervention designed to reduce transmission of multidrug-resistant organisms) personal protective equipment (PPE- protective equipment designed to protect and prevent spread of infection or illness) while handling Resident 4's gastrostomy tube (G-tube-an indwelling medical device inserted into the stomach) during a enteral feeding (a feeding tube that delivers nutrients directly into the stomach) administration. This failure had the potential to result in the spread of germs and bacteria that could result in infection and illness. 1. During a review of Resident 5's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/19/26, the AR indicated Resident 5 was admitted to the facility on [DATE] with diagnoses of fracture (a break or crack in a bone) of right lower leg, and muscle weakness (the muscles [a soft tissue in the body that helped a person move] did not work as strongly as they usually did). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/3/26, the MDS indicated Resident 5 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 5 was cognitively intact. During a concurrent observation and interview on 2/17/26 at 8:26 a.m. with Resident 5 in his room, Resident 5 stated he had developed a productive cough beginning on 2/14/26. Resident 5 stated he had been receiving cough syrup, and throat lozenges and had undergone a chest X-ray (imaging test to take pictures of the inside of the body), with results pending at the time of interview. Resident 5 described the cough as painful and stated no other testing had been performed aside from the chest X-ray. During an interview of 2/19/26 at 9:29a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated her role was to observe residents and report any changes in condition to the nurse immediately. CNA 1 stated if a resident had a cough, she would report it to the nurse. During a concurrent interview and record review of Resident 5's electronic health record on 2/19/26 at 10:09a.m. with Registered Nurse (RN)1, RN 1 stated she was the nurse assigned to Resident 5 on 2/14/26 when he developed a cough. RN 1 stated the facilities COVID-19 protocol required resident's exhibiting signs or symptoms of COVID-19 to be tested. RN 1 stated Resident 5 was not tested for COVID-19. Review of Resident 5's Medication Administration Record (MAR) indicated Resident 5 had a PRN (as needed) order for COVID-19 testing, which had not been administered. RN 1 stated testing was important to determine the resident's COVID-19 status. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and review of Resident 5's electronic health record with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated Resident 5 had developed a cough. The IP/DSD stated she was unsure why the nurse did not test Resident 5 for COVID-19. The IP/DSD stated it was important to identify COVID-19, because it spreads rapidly. The IP/DSD stated the nurse assesses residents and determines if they meet criteria for testing. The IP/DSD further stated testing would have been beneficial to determine Resident 5's COVID-19 status. The IP/DSD stated COVID-19 tests are performed in-house with results available within 15 minutes. During a concurrent interview and record review on 2/20/26 at 12:52 p.m. with the Director of Nursing (DON), the facilities policy and procedure (P&P) titled, COVID-19, date unknown was reviewed. The P&P indicated, clinical criteria: at least one of the following symptoms-cough. The DON stated Resident 5 should have been tested according to the policy, as he already had a PRN order for testing. The DON stated staff could always test for COVID-19. The DON described Resident 5 as being in and out of the facility and stated there was always a risk when individuals were in and out of the facility. 2. During a review of Resident 4's (AR), dated 2/19/26, the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (a condition of inadequate blood supply to the brain caused by a blockage), gastrostomy status (refers to a surgically opening in the stomach), type 2 diabetes mellitus (a condition of a high buildup of sugar in the blood), and dysphagia (difficulty swallowing). During a review of Resident 4's (MDS), dated [DATE], the MDS indicated Resident 4 had a (BIMS) score of 3 which suggested Resident 4 was severely cognitively impaired. Resident 4's MDS indicated he had a feeding tube. During a review of Resident 4's Order Summary Report (OSR), dated 2/19/26, the OSR indicated, Resident 4 had an active order for enteral feed every 4 hours via G-tube. The OSR indicated Resident 4 was on Enhanced Barrier Precautionsfor enteral feeding via G-tube. During an observation on 2/17/26 at 8:47 a.m., outside of Resident 4's room, Resident 4's room door had an EBP sign posted. The EBP sign stated, .providers and staff must also: wear gloves and gown for the following high-contact resident care activities.device care or use. During a concurrent observation and interview on 2/18/26 with Licensed Vocational Nurse (LVN) 1, in Resident 4's room, LVN 1 was observed handling Resident 4's G-tube with gloves while administering his enteral feeding. LVN 1 was not observed wearing a gown while handling Resident 4's G-tube. During an interview on 2/19/26 at 2:11 p.m. with the Infection Preventionist (IP/DSD), the IP/DSD stated residents with indwelling medical devices, such as G-tubes, were at increased risk of infections. The IP/DSD stated all residents with G-tubes were placed on EBP and staff were required to wear gowns and gloves when handling G-tubes. The IP/DSD stated EBP's were for resident protection and ensured infections were not introduced through the indwelling medical device during handling. During an interview on 2/19/26 at 3:26 p.m. with LVN 1, LVN 1 stated he had not worn a gown while handling Resident 4's G-tube. LVN 1 stated Resident 4 was on EBP and staff were required to wear PPE, gown and gloves, when handling Resident 4's G- tube during enteral feedings to prevent the spread of infections. LVN 1 stated Resident 4's G-tube was an indwelling medical device and Resident 4 was at increased risk of infection if staff did not wear PPE while handing his G-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON), the DON stated Resident 4 had a G-tube and was on EBP. The DON stated enteral feeding was a high-contact resident care activity. The DON stated per standards of practice and facility policy PPE, gown and gloves, were both required to be worn when handling Resident 4's G-tube. The DON stated facility policy was not followed when LVN 1 did not wear a gown while administering Resident 4's enteral feeding. The DON stated Resident 4 was placed at increased risk of infection when LVN 1 did not follow EBP policies. During a record review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, undated, the P&P indicated, .enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [Multidrug-resistant organisms that are resistant to many antibiotics] as well as those at increased risk of MDRO acquisition (e.g., residents with.indwelling medical devices.).signage will be posted on the door or wall outside the resident room indicating the type of precaution, required personal protective equipment (PPE) , and the high-contact resident care activities that require the use of gown and gloves.make gown and gloves available prior to performing tasks.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a complete and accurate informed consent was obtained prior to the administration of psychotherapeutic medication (prescription drugs designed to manage mental and emotional disorders by altering the brain's chemical makeup and nervous system) for one of five sampled residents (Resident 3) when Resident 3, who was her own representative party (RP-a person designated to received updates of resident's care and make decisions), did not sign an informed consent and was administered clonazepam (psychotherapeutic medication used to manage anxiety disorders) 0.5 milligrams (mg- a unit of measurement for medication dosage).This failure resulted in Resident 3's clonazepam informed consent not being complete and accurate prior to administration which lead to Resident 3 not being fully informed prior to receiving psychotherapeutic medication. During a review of Resident 3's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 2/19/26, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of rhabdomyolysis (rapid breakdown of skeletal muscle releasing toxins into the blood), spinal stenosis (narrowing of spinal canal), chronic pain syndrome, and anxiety disorder (excessive, persistent fear or worry). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/6/26 , the MDS indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3 was cognitively intact.During a review of Resident 3's Medical Record, dated 2/19/26, the Order Listing Report (OLR), indicated Resident 3 had an order for clonazepam 0.5 mg every 12 hours, as needed (PRN), for anxiety, from 2/5/26 to 2/17/26. The OLR indicated Resident 12's clonazepam 0.5 mg order was revised on 2/17/26 to be given every 12 hours, scheduled, for 14 days. Resident 3's Psychotherapeutic Drug Informed Consent Form (IC), dated 2/5/26, indicated informed consent had been obtained for Resident 3's clonazepam 0.5 mg every 12 PRN order. Resident 3's Medical Record did not indicate a new IC had been obtained for clonazepam 0.5 mg every 12 hours, scheduled, before administration. Resident 3's Medical Record indicated, clonazepam 0.5 mg every 12 hours, scheduled, had been administered on 2/17/26 at 9:00 p.m. and 2/18/26 at 9:00 a.m., before Resident 3 signed an IC.During a concurrent interview and record review on 2/18/26 at 9:54 a.m. with Registered Nurse (RN) 1, Resident 3's Medical Record, dated 2/18/26 was reviewed. RN 1 stated Resident 3 was her own RP and signed her own informed consents. RN 1 stated she could not locate an informed consent for Resident 3's clonazepam 0.5 mg, every 12 hours, for 14 days, scheduled order. RN 1 stated she could only locate Resident 3's previous order, clonazepam 0.5 mg every 12 hours, PRN, informed consent. RN 1 stated the current informed consent did not match the current order for clonazepam. RN 1 stated any time a psychotherapeutic medication changed, including frequency, a new informed consent was required. RN 1 stated it was important to obtain an informed consent prior to administration of psychotherapeutic medication to ensure the resident was aware of risks, benefits and potential side effects of the medication they were administered. During an interview on 2/18/26 at 10:54 a.m. with Resident 3, in Resident 3's room, Resident 3 stated she was unaware her clonazepam 0.5 mg medication was switched from PRN to scheduled every 12 hours. Resident 3 stated she requested the medication be changed from PRN to every 12 hours scheduled, so she could receive the medication at 9 a.m. and 9 p.m., but she did not know it had gone into effect yet.During a concurrent interview and record review on 2/18/26 at 9:47 a.m. with the Medical Records (MR), Resident 3's Medical Record, dated 2/18/26 was reviewed. The MR stated after informed consents (continued on next page)

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Morning Star Post Acute	111 Barstow Ave. Clovis, CA 93612

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were obtained they were brought to her to upload into the resident chart. The MR stated she reviewed informed consents before upload into the Medical Record to ensure accuracy and completion. The MR stated informed consents required Resident and/or Resident's RP signatures to ensure informed consent was obtained. The MR could not locate a consent for Resident 3's clonazepam 0.5 mg every 12 hours scheduled order.During a concurrent interview and record review on 2/19/26 at 3:49 p.m. with the Director of Nursing (DON), Resident 3's Medical Record, dated 2/19/26, was reviewed. The DON stated Resident 3 was a BIMS of 15, made her own medical decisions and signed her own informed consents. The DON stated on 2/17/26 Resident 3, the provider, and herself spoke on the phone and the provider agreed to switch Resident 3's medication from PRN to scheduled, as per Resident 3's request. The DON stated the provider gave a verbal order to give the medication scheduled. The DON signed her signature, as the receiving licensed nurse of the verbal order, on Resident 3's informed consent on 2/17/26. The DON stated Resident 3 did not sign the informed consent. The DON stated Resident 3's medication was then administered. The DON stated she was taught since the provider was not at bedside, Resident 3 could not sign the informed consent until the provider was at bedside. The DON stated she signed, as the licensed nursing staff, to give informed consent for Resident 3 on 2/17/26. The DON stated on 2/18/26 Resident 3 and the provider signed the informed consent. The DON stated Resident 3 had received two doses of clonazepam 0.5 mg every 12 hours, scheduled, before Resident 3 signed the informed consent.During an interview on 2/20/26 at 12:22 p.m. with the DON, the DON stated she could not locate a policy, in-service, or education that supported Resident 3 not being able to sign informed consent if the provider was not at bedside. The DON stated she reviewed facility policy, previous in-services and education, and facility policy had not been followed in obtaining informed consent for Resident 3. The DON stated licensed nursing staff could sign in place of the resident in emergent situations, but emergent conditions were required to be documented, which they were not. The DON stated an informed consent was required for all psychotherapeutic medications and when medication changes occurred. The DON stated informed consents were important to obtain to ensure residents were aware of their medication, risks, benefits and plan of care changes.During a review of the facility's manual title, California LTC Facility Pharmacy Services and Procedures Manual, the policy and procedure (P&P) titled, 3.8 Psychotropic Medication Use, dated 12/1/07, indicated .all medications used to treat behaviors must have clinical indication.facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulations.During a review of the facility's P&P titled, Informed Consent, dated 1/1/26, the P&P indicated, .the facility shall ensure that informed consent is obtained, documented, maintained, and renewed for all psychotherapeutic drugs administered to residents in accordance with California law, resident rights requirements, and the California Department of Public Health (CDPH) Psychotherapeutic Drug Informed Consent Form CDPH 9168.Psychotherapeutic medications shall not be initiated or continued without valid informed consent, expect in documented emergency situations as permitted by law. this policy applies to all physicians.licensed nurses.pharmacy consultants, and medical records personnel involved in prescribing, administration, monitoring, and documentation of psychotherapeutic medications.a separate CDPH 9168 form shall be completed for each psychotherapeutic drug.informed consent must be obtained prior to administration of the psychotherapeutic drug.consent shall be obtained from the resident or the resident's legally authorized representative.the resident or representative shall sign and date section 15 of the CDPH 9168 form.if the resident of representative is unable to sign the consent form, a licensed nurse may document verification of consent.the licensed nurse shall complete and sign section 16 of the CDPH 9168 form, documenting diligent efforts to obtain the signature and the date consent was provided.in emergency situations where immediate medication is necessary and consent cannot be obtained, psychotherapeutic medication may be administered as clinically indicated.the emergency circumstances and rationale shall be clearly documented.consent shall also be re-obtained when there (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is a significant dosage change, medication change, restart after discontinuation, or identification of new risk.During a review of the facility's P&P titled, Resident Rights, dated 9/22/22, the P&P indicated, .the resident has the right to be informed of, and participate in, his or her treatment, including: .the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.the right to be informed, in advance, of changes to the plan of care.the right to be informed by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure its policy on against medical advice (AMA-patient chooses to leave before the doctor recommended discharge) was followed for one of three sampled residents (Resident 57) when Resident 57 left the facility AMA on 2/6/26, and there was no documentation the medical doctor (MD) and administrator (ADM) were notified.This failure had the potential to place Resident 57 at risk of health complications, including worsening of her condition. During a review of Resident 57's admission Record (AR- a document containing resident profile information) dated 12/9/25, the AR indicated Resident 57 was admitted to the facility on [DATE] with diagnoses which included right hip effusion (abnormal accumulation of excess fluid within the hip joint capsule), spinal stenosis (narrowing of spinal canal squeezing the nerves and causing pain, numbness, tingling, or weakness), muscle weakness and abnormalities of gait and mobility. During a review of Resident 57's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 57's Brief Interview for Mental Status (BIMS-screening tool sed to assess resident cognitive status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit)assessment score was 13 out of 15 which indicated Resident 57 had no cognitive deficit.During an interview on 2/19/26 at 3:01 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was working the day Resident 57 signed herself out AMA and assisted Resident 57's nurse with the process. LVN 1 stated Resident 57 was not happy and wanted to leave. LVN 1 stated he explained what AMA meant and the potential consequences, and Resident 57 signed the AMA form. LVN 1 stated he did not remember notifying or calling the MD and the ADM regarding of Resident 57's decision to leave AMA. During a concurrent interview and record review on 2/19/26 at 3:18 p.m. with Registered Nurse (RN)2, RN 2 stated she was Resident 57's nurse when Resident 57 signed herself AMA on 2/6/26. RN 2 reviewed Resident 57's progress notes and stated she sent a message to the Director of Nursing (DON) but did not notify Resident 57's MD or the ADM. RN 2 stated she assumed the DON notified the ADM. RN 2 stated, I am new in the facility and did not know what to do. During a concurrent interview and record review on 2/20/26 at 10:49 a.m. with Social Service Designee (SSD), Resident 57's SSD notes were reviewed. The SSD stated she did not find any documentation indicating she had spoken with Resident 57 about wanting to go home or requesting a room change. The SSD stated Resident 57 was not happy with her roommate and had been shown different room where she could have moved. The SSD stated she should have notified the ombudsman (an official advocate for resident's rights), but she did not, and did not call Resident 57 to follow-up after leaving AMA. During an interview on 2/20/26 at 12:20 p.m. with the DON, the DON stated, She (Resident 57) threatened to leave so many times and we talked to her but there are no documentations. The DON stated she was not sure about the facility policy on AMA, but we can not keep them against their will. The DON stated she reviewed the nurse documentation when Resident 57 signed herself out AMA. The DON stated the nurse progress note did not indicate the MD and ADM were notified or made aware of Resident 57's decision to leave AMA. During a review of facility's policy and procedure (P&P) titled, Transfer and Discharge (Including AMA), dated 12/19/22, the P&P indicated, . b. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. c. Documentation of this notification should be entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes .

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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 five sampled residents (Resident 58) when Resident 58's Infection of the foot in Section M (Skin Condition) was inaccurately coded in the MDS assessment dated [DATE]. This failure had the potential to result in Resident 58's care needs not met and the potential for adverse reaction to not be monitored.During a concurrent observation and interview on 2/17/26 at 10:48 a.m. during initial tour in Resident 58's room, Resident 58 was observed lying in bed with facial grimacing stating he has pain on his right foot. Resident 58's right foot was covered with kerlix roll dressing (sterile, crinkled, cotton gauze bandage used to cover, protect, and pack wounds) from above the left ankle to toes, left foot covered with elastic bandage (stretchy, woven, and reusable fabric wrap) from below the knee to the toes. Resident 58 stated, The nurse said it is too soon for another pain medication. During a review of Resident 58's admission Record [AR-a document with personal identification and medical information], dated 2/19/26, the AR indicated Resident 58 was re-admitted to the facility on [DATE] with diagnoses which included Methicillin Resistant Staphylococcus Aureus (MRSA-a bacteria that does not respond to antibiotic [medicines that treat bacterial infections by killing bacteria or stopping their growth]) Infection, diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and absence of other right toes. During a review of Resident 58's Order Summary Report [OSR], dated 2/19/26, the OSR indicated, .Clean wound to [R] plantar [bottom] foot with NS [Normal Saline-salt water solution] & Pat Dry. Apply iodine soaked gauze to the area and wrap w/ [with] Kerlix QD [daily] . Order Date: 2/16/26, Start Date: 2/17/26 . Clean wound to right heel with NS, pat dry . Start Date 2/17/26 . Vancomycin [antibiotic used to treat severe infections] . Use 250 ml [milliliter-unit measurement] intravenously [into a vein]one time a day for MRSA to BLE [bilateral lower extremity] wounds . Order Date: 2/13/26, Start Date: 2/13/26 . During an interview on 2/17/26 at 9:15 a.m. with Infection Preventionist (IP), the IP stated Resident 58 is on Isolation Precaution due to MRSA to wounds on his feet. The IP stated Resident 58 is currently on intravenous antibiotics for the wounds to his feet. The IP stated Resident 58's wounds are covered with dressings and changed daily. During an interview on 2/19/26 at 9:24 a.m. with Certified Nursing Assistance (CNA) 4, CNA 4 stated she was familiar with Resident 58's care. CNA 4 stated Resident 58 complained of pain on his feet and did not want to be touched to take care of him. During a concurrent interview and record review on 2/19/26 at 1:25 p.m. with the Assistant Director of Nursing/Infection Preventionist (ADON/IP), Resident 58's clinical record was reviewed and she stated Resident 58 was sent out to acute hospital on 1/19/26 for debridement (cleaning out a wound to allow healthy, new tissue to grow) of wounds to bilateral heels. The ADON/IP stated Resident 58 has chronic wounds to heel area. The ADON/IP stated Resident 58 was re-admitted on [DATE] with intravenous antibiotic for MRSA until 3/3/26. During a concurrent interview and record review on 2/20/26 at 11:12 a.m. with Minimum Data Set Coordinator (MDSC), MDSC reviewed Resident 58's Admission/Medicare MDS assessment dated [DATE] Section M, MDSC stated Resident 58 is currently on antibiotic for MRSA to wounds on his foot and did not marked in Section M Resident 58 has infection of the foot. The MDSC stated, I made a mistake, I should have marked it yes. The MDSC stated she will make the correction. The MDSC stated it was her responsibility to ensure MDS assessment were accurate. During an interview on 2/20/26 at 12:30 p.m. with the Director of Nursing (DON), the DON stated her expectation was to ensure MDS assessments are accurate for reimbursement. The DON stated, Accurate MDS assessment was important so we know what is going on with a patient. During a review of the facility document titles, Job Description: MDS, dated [DATE], the Job Description indicated, . Conduct and coordinate the development and completion of the resident assessment (MDS) in accordance with (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	current rules, regulations, and guidelines that govern the resident assessment . Maintain and periodically update written policies and procedures that govern the development, use, and implementation of the resident assessment . During a review of facility's policy and procedure (P&P) titled, Conducting an Accurate Resident Assessment, dated 12/19/22, the P&P indicated, .The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status .

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F 0911 Level of Harm - Potential for minimal 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** Based on observation during the survey period of 2/17/26 through 2/20/26, the facility failed to ensure each bedroom accommodated no more than four residents in 3 of 16 rooms (rooms [ROOM NUMBER]). This failure had the potential for residents to not have reasonable privacy or adequate space.Findings: During the initial tour on 2/20/26 at 10:53 a.m., the following rooms had more than four residents in each bedroom. Although the bedrooms accommodated more than four residents, each room met the particular needs of each resident. There was adequate closet and storage space. Wheelchair and toilet facilities were accessible. There was sufficient room for nursing care and for residents to ambulate. Bedside stands were available for each resident. The health and safety of residents would not be adversely affected by the continuance of this waiver. Room Number Number of Beds11 812 714 8 Recommend waiver continue in effect. _____HFES Signature Date Request waiver continue in effect. _____ Facility Administrator Signature Date