STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555179	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Point Healthcare & Wellness Centre LP	668 E. Bullard Fresno, CA 93710

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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 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. 52452 Based on observation, interview, record review, and facility policy review, the facility failed to ensure the licensed nursing staff clarified a medication order with the physician. The pharmacy sent empagliflozin 10 milligrams (mg) to the facility 26 times from 10/2024 to 03/2025 and the licensed nursing staff never informed the physician that the medication was being delivered and the pharmacy never notified the physician that the medication had been ordered by the resident's cardiologist for 1 (Resident #28) of 4 residents observed for medication administration. Findings included: A facility policy titled, Medication Ordering and Receiving from Pharmacy updated 03/2024, revealed Medication are administered only upon the clear, complete and signed order of a person lawfully authorized to prescribe. The policy specified, (b) If the order is from a prescriber other than the attending physician, the order is verified with the current attending physician. An Admission Record indicated the facility admitted Resident #28 on 10/09/2023. According to the Admission Record, the resident had a medical history that included diagnosis of hypertensive heart disease and type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/18/2025, revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #28's Care Plan Report, indicated a focus area initiated 10/10/2023 and revised 10/16/2023, that indicated the resident had diabetes mellitus with neuropathy and hyperglycemia. Interventions directed staff to administer diabetes medication as ordered by the doctor. During a concurrent interview and medication administration observation on 03/25/2025 at 8:22 AM, Licensed Vocational Nurse (LVN) #1 removed four pills, to include empagliflozin 10 milligrams (mg), from a medication cup and did not administer the medication to Resident #28. LVN #2 stated she did not administer the medication because she could not determine if the medication was supposed to be administered. Resident #28's Order Summary Report that contained active orders as of 03/01/2025, revealed no evidence of a physician order that directed the staff to administer empagliflozin 10 mg to the resident. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28's Medication Administration Record [MAR] for the timeframe 03/01/2025 - 03/31/2025, revealed no evidence of the transcription of a physician's order for empagliflozin 10 mg. During an interview on 03/25/2025 at 8:58 AM, LVN #1 stated she removed empagliflozin from Resident #28's medication cup as the medication was not listed on the resident's MAR and there was no physician's order. During an interview on 03/27/2025 at 1:04 PM, the Pharmacy Consultant stated the order for empagliflozin 10 mg for Resident #28 was never ordered through the facility's Primary Physician and the resident had never been on empagliflozin 10 mg since admission to the facility. During an interview on 03/27/2025 at 1:19 PM, the Pharmacist stated the pharmacy received the prescription for empagliflozin 10 mg directly from Resident #28's cardiologist's office on 10/02/2024. Per the Pharmacist, the medication had been sent every week in the medication roll to the facility. A New Prescription Summary from Resident #28's cardiologist, revealed an order dated 10/02/2024, for empagliflozin 10 mg, take one tablet by mouth every morning. The pharmacy Fill History, revealed the pharmacy dispensed empagliflozin 10 mg to the facility 26 times from 10/03/2025 to 03/26/2025. During an interview on 03/27/2025 at 2:06 PM, LVN #4 stated he worked twice a week and gave Resident #28 their day-shift medications. LVN #4 stated that when he gave the medication, he verified the medication to the MAR then placed the medication into the medication cup. LVN #4 stated he noticed Resident #28 had a empagliflozin 10 mg to be given at the 8:00 AM, but he never saw it on the resident's MAR or in their orders, so he took it out, took it to the medication room, placed the pill in the destruction box, and informed his supervisor. LVN #4 stated he never gave the medication to the resident. According to LVN #4, the process would be to contact the pharmacy and let them know about the medication was always in the resident's roll of medications, but there was no order for it. During an interview on 03/27/2025 at 2:16 PM, LVN #2 acknowledged that LVN #4 told him about the empagliflozin medication in Resident #28's medication rolls and that it was not ordered or on the resident's MAR. LVN #2 stated he faxed the pharmacy but could not remember when. During an interview on 03/27/2025 at 2:47 PM, LVN #3 stated Resident #28 had the medication empagliflozin in their pills, to be given at 8:00 AM. LVN #3 stated she always took the medication out, did not administer it to the resident, destroyed the medication, and notified her supervisor. LVN #3 acknowledged she never called the pharmacy to report the medication. During a follow-up interview on 03/27/2025 at 3:00 PM, the Pharmacist stated the pharmacy never received an order to discontinue the empagliflozin 10 mg medication and there had been no information or communication about the medication from the facility. According to the Pharmacist, if a facility nurse called and stated there was not a physician order for the medication, they would instruct the staff to send over an order to discontinue the medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/27/2025 at 3:41 PM, Resident #28's Primary Physician (PP) stated he took over care of the resident in late February 2025. The PP stated the empagliflozin medication was ordered by the resident's cardiologist back in October of 2024, and the pharmacy should have never sent it to the facility, if he did not order it. The PP stated he expected that if a medication was not listed on a resident's MAR and there was no order for the staff to call the pharmacy or physician for clarification. The PP stated the doctor who ordered the medication should have sent a note to the facility and he would have reviewed it to determine if the resident needed it. The PP stated neither the pharmacy nor the facility called him about the issue. During an interview on 03/27/2025 at 3:54 PM, the Director of Nursing (DON) stated her expectations were if the facility did not have an order for a resident's medication, the nurse should call the pharmacy and let them know that a medication did not have an order, and it needed to be stopped. The DON stated that no one told her that the medication. The DON stated the nurse should also call the physician and tell him that the medication came without an order, and he could manage it and/or discontinue it. During an interview on 03/27/2025 at 4:06 PM, the Administrator stated her expectation would be that the nurse and the DON follow the facility policy.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52452 Based on observation, interview, record review, and facility policy review, the facility failed to maintain a medication error rate of 5 percent (%) or less. There were two errors out of 35 opportunities, which resulted in a 5.71% medication error rate for 1 (Resident #28) of 4 residents observed for medication administration. Findings included: A facility policy titled, Medication-Administration revised 01/01/2012, revealed Purpose To ensure the accurate administration of medications for resident in the Facility. Policy I. Medication will be administered directed by a Licensed Nurse and upon the order of a physician or licensed independent practitioner. II. No medication will be used for any patient other than the patient for whom it was prescribed. An Admission Record indicated the facility admitted Resident #28 on 10/09/2023. According to the Admission Record, the resident had a medical history that included a diagnosis of primary open-angle glaucoma, bilateral. Resident #28's Order Summary Report that contained active orders as of 03/01/2025, revealed an order dated 12/17/2024, for [brand name] ophthalmic solution 2-0.5 %, instill one drop in both eyes two times a day for glaucoma and an order dated 12/06/2023, for vitamin c oral tablet 500 milligrams, give one tablet by mouth two times a day for supplement. During medication administration observation on 03/25/2025 at 8:22 AM, Licensed Vocational Nurse (LVN) #1 failed to administer Resident #28's [brand name] ophthalmic solution eye drops and vitamin c tablet according to physician orders. During an interview on 03/25/2025 at 11:37 AM, LVN #1 acknowledged that she did not give Resident #28 vitamin c or the [brand name] eye drops. LVN #1 stated she did not give the medications but acknowledged she placed her initials on the resident's electronic medication administration record as if the medication had been administered. During an interview on 03/25/2025 at 12:50 PM, the Director of Nursing stated she expected a nurse to verify the medication order while the medication was being prepared for administration. During an interview on 03/27/2025 at 4:06 PM, the Administrator stated she expected a nurse to follow the policy.

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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. 40141 Based on observation, interview, record review, and facility policy review, the facility failed to ensure gloves were changed between dirty and clean tasks for 2 (Resident #7 and Resident #76) of 2 sampled residents reviewed for pressure ulcer/injury. Findings included: A facility policy titled, Dressings- Application, revised 01/01/2012, indicated, Remove dressings and discard into plastic bag. The policy indicated, Remove and discard non-sterile disposable gloves in plastic bag at bedside. Wash hands before and after each procedure. A facility policy titled, Hand Hygiene, revised 09/01/2020, indicated, The following situations require hand hygiene: After contact with blood, other body fluids, secretions, excretions, mucous membranes, non-intact skin, wound drainage and soiled dressing. 1. An Admission Record indicated the facility admitted Resident #7 on 02/12/2025. According to the Admission Record, the resident had a medical history that included a diagnosis of stage 3 sacral pressure ulcer. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/19/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had one or more unhealed pressure ulcers/injuries. Resident #7's Order Summary Report, with active orders as of 03/22/2025, contained an order dated 03/22/2025, that directed staff to clean the coccyx stage 3 pressure injury with normal saline, pat dry, apply medical honey gel, and cover daily. Resident #7's Care Plan Report, included a focus area initiated 03/26/2025, that indicated the resident had a stage 3 pressure injury to the coccyx. Interventions directed staff to administer treatments as ordered and monitor for effectiveness. During an observation on 03/26/2025 at 9:15 AM, Licensed Vocational Nurse (LVN) #1 provided wound care for Resident #7. LVN #1 with gloved hands removed a dressing from the resident's coccyx. Without changing gloves or performing hand hygiene, LVN #1 obtained gauze and normal saline and cleaned the open pressure ulcer with the same gloved hands. LVN #1 then removed her gloves, washed her hands, reapplied gloves, and completed the wound care. During an interview on 03/26/2025 at 12:26 PM, LVN #1 stated when she cleaned a wound, she used gloves because the wound was soiled. LVN #1 stated she changed gloves after she cleaned the wound because then the wound was considered clean to apply the treatment. LVN #1 stated she set up a clean barrier for the supplies to have a clean area. LVN #1 stated the wound dressing was considered dirty that she removed. LVN #1 stated she set up gauze in separate piles, and after she removed the dressing she reached over to the clean area slowly, got the gauze and normal saline, cleaned the wound, and then removed gloves, washed her hands, and applied gloves to finish treatment. (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 on 03/26/2025 at 2:13 PM, the Infection Preventionist (IP) stated the process for changing gloves during wound care was if anything dirty was touched then change gloves and perform hand hygiene before touching anything clean. The IP stated if the staff removed a soiled dressing they should perform hand hygiene before they touched clean supplies. The IP stated that the treatment nurse should have changed her gloves after she removed the dressing during wound care. According to the IP, not changing gloves after removing the dressing was dirty and that was an infection control issue. During an interview on 03/27/2025 at 9:42 AM, the Director of Nursing (DON) stated it was important to change gloves between dirty and clean because it was for infection control. The DON stated LVN #1should have changed her gloves after she removed the dressing. The DON stated her expectation was for gloves to be changed after removing a dressing during wound care because that was dirty to clean and they should always change gloves. During an interview on 03/27/2025 at 9:50 AM, the Administrator stated the importance of changing gloves between dirty and clean tasks so staff did not cross contaminate items. The Administrator stated LVN #1 should have changed her gloves at the time she removed the dressing from the resident's coccyx before she touched the gauze and normal saline on the clean area. The Administrator stated she expected gloves to be changed between dirty and clean tasks. 52452 2. An Admission Record indicated the facility admitted Resident #76 on 10/03/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and encounter for palliative care. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 01/03/2025, revealed Resident #76 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident had one or more unhealed pressure ulcers/injuries. Resident #76's Care Plan Report, indicated a focus area initiated 03/26/2024, that indicated the resident had a stage 3 coccyx pressure ulcer. Interventions directed the staff to administer treatments as ordered and monitor the effectiveness. Resident #76's Order Summary Report with active orders as of 03/01/2025, revealed an order dated 02/10/2025, that directed the staff to clean the resident's coccyx stage 3 pressure injury and peri wound with betadine solution, pat dry, apply Dakin's solution, moisture gauze to the wound base and cover with foam boarder every day and evening shift. During an observation of wound care on 03/26/2025 at 10:14 AM, Licensed Vocational Nurse (LVN) #1 removed the soiled dressing from the resident's coccyx area and placed it in the bag. LVN #1 then proceeded to reach over with her soiled gloved hand and picked up several clean 4x4 gauze and proceeded to pat dry the resident's buttock and area around the pressure ulcer. LVN #1 then picked up several clean 4x4s and placed them into the betadine solution and proceeded to clean around and into the deep pressure ulcer. After cleaning the entire area, LVN #1 discarded the betadine soaked 4x4s into the plastic bag, removed her gloves, and washed her hands with soap and water. (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 on 03/26/2025 at 10:31 AM, LVN #1 stated that the removal of the soiled dressing and the cleansing of the wound was all one step. LVN #1 stated the dressing was dirty, and the patting and cleaning of the wound with the betadine solution was also a dirty part of the procedure. LVN #1 stated she did not need to change her gloves after she removed a dirty dressing because she was not done cleaning the dirty wound. During an interview on 03/26/2025 at 3:47 PM, the Director of Nursing (DON) stated that her expectation would be that each nurse would follow the policy and procedure for hand hygiene and dressing application. The DON stated the nurse who completed Resident #76's wound care should have removed her soiled gloves and washed her hands after she removed the soiled dressing from the resident's coccyx wound before she began to clean it. During an interview on 03/26/2025 at 3:51 PM, the Regional Quality Assurance Nurse stated her expectations were that the nurse should remove their gloves and wash their hands after they removed a soiled dressing from a resident's wound and prior to cleaning the wound. During an interview on 03/27/2025 at 10:22 AM, the Administrator stated the nurse should change her gloves between dirty and clean tasks and follow the facility policy and procedures.