STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555347	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Starr Postacute Care	180 Starr Avenue Turlock, CA 95380

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to revise Resident 11's comprehensive care plan to address a significant change in condition following hospitalization for suspected infected dialysis access (the site used to connect the resident to dialysis, a treatment that cleaned the blood when the kidneys could not do so), treatment with intravenous (IV) antibiotics (medicine given through a vein directly into the blood stream to treat infection), and replacement of the dialysis catheter (a flexible tube placed into a large vein to allow dialysis treatments). This failure had the potential to result in the residents' care needs not being identified, communicated and addressed through coordinated interdisciplinary care planning upon the residents' return to the facility. Findings:During an observation on 5/5/26 at 12:02 p.m., Resident 11 was observed in the dining room eating lunch. No issues or concerns were observed at that time. During a review of Resident 11's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 11 was admitted to the facility on [DATE] with a diagnosis which included end stage renal disease, stage 5 (the kidneys had almost completely stopped working and could no longer clean the blood or remove extra fluid from the body, so dialysis was needed to do the job the kidneys could no longer do) and type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control). During a review of Resident 11'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 11's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 12 indicated Resident 11 was moderately cognitively impairedDuring a concurrent interview and review of Resident 11's electronic health record on 5/7/26 at 1:33p.m. with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 11 was initially admitted to the facility on [DATE] and was hospitalized from [DATE] through 4/28/26 after being sent from dialysis for a possible dialysis catheter infection. LVN 1 stated Resident 11's dialysis catheter was removed during the hospitalization, and a new dialysis catheter was placed, and Resident 11 received intravenous (IV) antibiotics (medication given directly into the bloodstream through a vein to treat infection) while hospitalized . During a concurrent interview and review of Resident 11's electronic health record on 5/8/26 at 9:41 a.m. with LVN 2, LVN 2 stated when a resident experienced a change in condition, staff were expected to assess the resident, notify the physician, follow physician recommendations, notify the responsible party (RP), document the event in a progress note, initiate or create a care plan, follow up with the hospital and discuss the residents status in an interdisciplinary team (IDT) meeting with interventions added as needed. Review of Resident 11's progress notes revealed documentation that Resident 11's RP notified the facility Resident 11 had been sent to the hospital by dialysis facility staff due to drainage from the dialysis catheter site. Further review of Resident 11's electronic health record did not reveal a care plan addressing the hospitalization, physician notification, follow up care, or discharge planning after his return to the facility. No documentation (continued on next page)

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

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was identified indicating physician notification or an IDT meeting related to Resident 11's change in condition. LVN 2 stated No, this is not the way the process should have gone, and stated the process was important to ensure the resident's condition was tracked and the physician remained informed of the resident's status. During a review of Resident 11's Patient Discharge Instructions, dated 4/28/26, the Patient Discharge Instructions indicated the reason for the hospital visit was cutaneous hypersensitivity (skin sensitivity or skin reaction), cellulitis (a bacteria skin infection that can cause redness, swelling, warmth and pain) at the port site, and a diagnosis of portacath line problem (an issue with the implanted tube used to give medications or treatments directly into a large vein, such as infection, blockage, damage or improper function). During an interview on 5/8/26 at 12:10p.m. with the Director of Nursing (DON), the DON stated her expectation when a resident experienced a change in condition was for nursing staff to follow up with the hospital to obtain information, document the event, notify the physician, and for the social worker to follow up as needed. The DON stated if a change in condition occurred within the facility, nursing staff were expected to document the change in condition and notify the physician. The DON stated the expectation was to care plan the resident's hospitalization to support care planning upon the residents return and provide the resident with the best care. When asked whether a hospitalization related to suspected infection dialysis access represented a significant change in condition, the DON stated nursing staff should have had a care plan in place, as this was important for planning the residents care upon return to the facility. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated January 2018 the P&P indicated, Assessments of residents are ongoing and care plans are revised as information about the residents and residents' conditions change.the nurse and/or the interdisciplinary team must review and update the care plan: a. when there has been a significant change in the resident's conditionDuring a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated January 2026 the P&P indicated, 1. the nurse will notify the resident's attending physician or physician on all when there has been a (an): d. significant change in the resident's physical/emotional/mental condition, g. need to transfer the resident to a hospital/treatment center.2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and / or revision to the care plan.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted as required by current OBRA regulations governing resident assessments and as outlined in the MDS RAI instruction manual.During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident With, dated January 2018 the P&P indicated, 5. The residents comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure one (Resident 3) out of ten residents received a level II Pre-admission Screening and Resident Review (PASRR- evaluation for individuals suspected of having a Serious Mental Illness (SMI) or Intellectual/Developmental Disability (I/DD)/Related Condition (RC), triggered by a positive Level I screen, to determine if they need specialized services, ensuring placement in the least restrictive setting) evaluation by the designated entity to determine if SMI, ID/DD/RC conditions were present when Resident 3 had a PASSRR level I screening result positive for SMI and the facility did not ensure a PASRR level II screening was completed.This failure resulted in Resident 3 not receiving a required PASRR level II screening which could result in delayed treatment, identification of care or services.During a concurrent interview and record review on 5/6/26 at 2:48 p.m. with the Director of Nursing (DON), Resident 3's Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 9/16/26, and Notice of Attempted Evaluation, dated 9/19/26, was reviewed. The DON stated she was responsible for completing, reviewing and following up on all PASRR's. The DON stated when residents were admitted or had a significant change in condition a PASRR level I was completed. The DON stated all positive level I PASRR's required a level II PASRR evaluation. The DON stated on 9/16/26 Resident 3 had a significant change in condition when she transferred to hospice services and a level I PASRR was completed. The DON stated Resident 3's level I PASRR, on 9/16/26, was positive for SMI. The DON stated on 9/19/26 the facility received a PASRR level II letter, Notice of Attempted Evaluation, which stated the designated state agency could not reach the facility on two or more attempts to complete Resident 3's PASRR level II evaluation. The DON stated a level II PASRR was not completed.During an interview on 5/8/26 at 12:06 p.m. with the DON, the DON stated facility policy and procedure was not followed when Resident 3 had a positive level I PASRR and the facility did not ensure a level II PASRR was completed. The DON stated Resident 3 should have had a level II PASRR completed following a positive level II PASRR result on 9/16/26. The DON stated it was important to complete level II PASRR's in a timely manner to ensure the facility could meet the needs of residents with a positive level I PASRR. The DON stated Resident 3 was placed at risk for delayed treatment, identification of care or services.During a record review of Resident 3's document titled, Preadmission Screening and Resident Review (PASRR) Level I Screening, dated 9/16/26, the document indicated on 9/16/26 Resident 3 had a change in condition and the DON completed a PASRR level I evaluation. The document indicated Resident 3 was positive for SMI and required a PASRR level II screening evaluation by the designated state agency.During a record review of Resident 3's document titled, 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 5/7/26, the AR indicated Resident 3 was admitted on [DATE] with diagnoses of end stage renal disorder (kidney function decline requiring life-sustaining medical treatment), bipolar disorder (mental health condition resulting in mood swings) anxiety disorder (mental health condition resulting in persistent fear and worry), and schizophrenia (mental health condition affecting ability to think, feel and act).During a record review of Resident 3's document titled, Notice of PASRR Level I Screening Results, dated 9/16/26, the document indicated, .your facility will be contacted within two to four days to set up an appointment for an evaluator to conduct a Level II Mental Health Evaluation.During a record review of Resident 3's document titled, Notice of Attempted Evaluation, dated 9/19/26, the document indicated, .facility staff were unresponsive to two or more sperate attempts of communication within 48 hours of the Level I Screening.the case is now closed. To reopen, the facility must resubmit a new Level I Screening.please note this letter is a courtesy notice for administrative purposes only and does not comprise a completed individualized (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determination.During a record review of the facility's policy and procedure (P&P) titled, Preadmission Screening and Resident Review, dated 1/2018, the P&P indicted, .it is the policy of this facility to comply with federal and state regulations regarding the Preadmission Screening and Resident Review (PASRR) process. PASRR ensures that individuals with serious mental illness (SMI), intellectual disabilities (ID), or related conditions are appropriately placed in a skilled nursing facility (SNF) and receive necessary services.If the level I screening indicates a potential SMI, ID, or related condition, the resident must be referred for a level II PASRR evaluation conducted by the designated state agency.must follow up to ensure timely completion of the level II evaluation.the facility must receive written confirmation of level II results.if a significant change occurs, a new level I screening must be completed, and if necessary, a level II referral must be initiated.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to ensure oxygen therapy (a colorless, tasteless gas essential to living organisms) professional standards of practice were followed for one (Resident 20) of ten residents when Resident 20 did not have oxygen therapy signage posted.This failure resulted in Resident 20's oxygen concentrator (medical device that helps residents breathe) being on with no oxygen therapy signage posted in or outside her room which could result in fire, hazards or injuries.During an observation on 5/5/26 at 10:01 a.m. in Resident 20's room, Resident 20 was observed lying in bed. Resident 20's oxygen concentrator was observed on at 5 LPM (liter per minute-a unit of measurement for the flow rate of oxygen). Resident 20's nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) was on the floor.During a concurrent observation and interview on 5/5/26 at 10:30 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 20's room, Resident 20 was observed lying in bed. Resident 20's oxygen concentrator was observed on at 5 LPM (liter per minute-a unit of measurement for the flow rate of oxygen). Resident 20's nasal cannula was on the floor. LVN 1 stated Resident 20 had an order for oxygen therapy and the oxygen concentrator was on. LVN 1 stated Resident 20 did not have any signage indicating oxygen therapy was in use. LVN 1 stated all residents on oxygen therapy required oxygen therapy signage for safety. LVN 1 stated oxygen therapy safety signage notified residents, staff, and visitors to avoid flames and flammable material for risk of fire, injury and hazard.During an interview with the Director of Nursing (DON) on 5/8/26 at 12:06 p.m., the DON stated when oxygen therapy was ordered or an oxygen concentrator was turned on, oxygen therapy signage was required to be posted. The DON stated oxygen therapy signage alerted residents, staff and visitors to the use of oxygen and safety requirements to avoid smoking and open flames to prevent fire. The DON stated facility policy and procedure, as well as, oxygen therapy professional safety standards of practice were not followed when Resident 20 had an order for oxygen therapy and an oxygen concentrator tuned on with no oxygen therapy signage posted. The DON stated Resident 20, other residents, visitors and staff were placed at risk of fire, hazards or injuries.During a record review of Resident 20's Order Summary Report (OSR), dated 5/6/26, the OSR indicated Resident 20 had an order for nasal cannula oxygen therapy since 4/22/26.During a record review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 1/2018, the P&P indicated, .the purpose of this procedure is to provide guidelines for safe oxygen administration.the following equipment and supplies will be necessary when performing this procedure. No Smoking/Oxygen in Use signs.place an Oxygen in Use sign on the outside of the room entrance door.Place an Oxygen in Use sign in a designated place on or over the resident's bed.remove all potentially flammable items.in accordance with facility policy and professional standards of practice.During a professional reference review retrieved from https://www.lung.org/lung-health-diseases/lung-procedures-and-tests/oxygen-therapy/using-oxygen-safely , Oxygen Therapy: Using Oxygen Safely, dated 1/28/26, the professional reference review indicated, . post No Smoking and No Open Flames signs.turn off your oxygen when you're not using it.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure care and services were provided to maintain the highest practicable physical well-being for one of seven sampled residents (Resident 4) by failing to ensure an order for monitoring Resident 4's anticoagulant (a medication that helped prevent blood from clotting too easily, which could increase the risk of bleeding) adverse effects (unwanted or harmful side effects from a medication) was in place following readmission to the facility. This failure had the potential to delay identification of signs and symptoms of bleeding, placing Resident 4 at risk for adverse outcomes related to anticoagulant therapy. Findings:During an observation on 5/6/26 at 11:29 a.m. Resident 4 was observed asleep in bed with the bed in the lowest position. No obvious bruising was observed on the face or upper body. During a review of Resident 4's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 4 was initially admitted to the facility on [DATE] with a diagnosis which included embolism and thrombosis of an unspecified artery (a condition where a clump of blood blocked a blood vessel that carried blood away from the heart) and venous thrombosis and embolism (a condition where a clump of blood formed in a blood vessel that carried blood back to the heart and could move to another part of the body). During a review of Resident 4'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 4's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 5 indicating Resident 4 was severely cognitively impaired.During a concurrent interview and review of Resident 4's electronic health record with the Infection Preventionist (IP) on 5/6/26 at 2:49p.m., it was discovered Resident 4 had no current monitoring in place for anticoagulant adverse effects despite an active physician order for rivaroxaban (a medication used to help prevent harmful clumps of blood from forming, but it could also increase the risk of bleeding) 20 mg (milligram a way to measure the amount of medication in a dose) by mouth once daily and the care plan indicating monitoring for medication side effects. The IP stateed Resident 4 had been hospitalized from [DATE] through 5/4/26 and upon readmission, the anticoagulant side effect monitoring order was discontinued on 5/4/26 and not renewed or reordered. The IP stated it was important to monitor the Resident 4 for side effects associated with the medication. During a concurrent interview and review of Resident 4's electronic health record with LVN 2 on 5/8/26 at 9:34 a.m., LVN 2 stated if a resident was out of the facility for more than three days, new orders were obtained upon readmission. Review of Resident 4's electronic health record revealed monitoring for anticoagulant adverse effects was discontinued on 5/4/26 and not reordered until 5/6/26. LVN 2 stated it was the nurse's responsibility to ensure required monitoring orders were in place, as the purpose of monitoring was to assess signs and symptoms of bleeding. LVN 2 stated without monitoring in place, signs and symptoms of bleeding may not be identified. During a review of Resident 4's Medication Administration Record (MAR) from April 2026 through May 2026 it was indicated rivaroxaban 20 mg once daily was discontinued on 5/4/26 at 2:52p.m. and restarted on 5/5/26 at 9:00a.m. Review further indicated monitoring for signs and symptoms of bleeding related to anticoagulant therapy was discontinued on 5/4/26 at 2:52 p.m. and was not restarted until 5/6/26 at 11:00p.m. During a review of Resident 4's Care Plan Report dated 5/4/26, the Care Plan Report indicated Resident 4 was receiving anticoagulant therapy with rivaroxaban and included interventions to monitor for adverse reactions and effectiveness each shift. Interventions included daily skin inspection, monitoring for signs and symptoms of bleeding, including blood in urine, black tarry stools and red blood in stools, bruising, blurred vision, shortness of breath, changes in appetite and sudden changes in vital signs or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental status with instructions to report abnormalities to nursing staff. During an interview on 5/8/26 at 12:06p.m. with the Director of Nursing (DON), the DON stated it was her expectation nursing staff follow all hospital discharge orders upon resident readmission. The DON stated it was her expectation Resident 4's anticoagulant monitoring remained in place following readmission. When asked if residents receiving anticoagulant therapy should be monitored the DON stated yes, as monitoring was important to identify signs of bleeding. During a review of the facility's policy and procedure (P&P) titled, Anticoagulation-Clinical Protocol, dated January 2018 the P&P indicated, .assess for any signs or symptoms related to adverse drug reactions due to the medication alone.staff and physician will monitor for possible complications in individuals who are being anticoagulated.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post actual direct care staffing hours worked for public review for 21 of 21 residents in the facility, as required, by posting projected DHPPD (Direct Hours Per Patient Day) staffing information instead of actual hours worked for the prior day.This failure had the potential to prevent residents' family members and visitors from having accurate information regarding the actual nursing staffing levels providing care in the facility. Findings:During an observation on 5/6/26 at 10:05 a.m. in the facility lobby, the publicly posted Daily, Nursing Shift Staffing sheet dated 5/6/26, was reviewed. The document identified Projected DHPPD: 4.2 at the bottom of the posting. During an interview on 5/8/26 at 11:56a.m. with the Director of Nursing (DON), the DON stated she was responsible for posting the daily DHPPD staffing sheet each day. During a concurrent interview and review of the facility's Daily Nurse Shift Staffing sheet dated 5/6/26 and Appendix PP tag F732, dated 2/3/23, on 5/8/26 at 12:23p.m. with the DON, the DON stated the facility used the staff schedule and daily census to determine staffing needs and that she completed the staffing posting in the morning and again before leaving for the day. When asked whether a resident, family member or visitor reviewing the posted staffing sheet would be able to determine the actual hours worked for prior day, the DON stated no, as the facility did not post the actual hours worked. The DON stated the posted staffing sheet reflected projected staffing rather than actual hours worked. The DON stated residents, family members and visitors had the right to know who cared for their loved ones. During the interview, the DON reviewed Appendix PP, Tag F732, dated 2/3/23, and verbalized understanding that the regulation required posting actual hours worked rather than projected staffing hours. During a review of facilities policy and procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, dated January 2018, the P&P indicated, 3. Shift staffing information shall be recorded on the Nursing Staff Directly Responsible for Resident Care form for each shift. The Information recorded on the form shall include the following: g. the actual time worked during that shift for each category and type of nursing staff

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was stored, handled, and served in accordance with professional standards for food service safety when the ice machine was not secured and accessible to all residents, visitors, and staff.This failure resulted in the ice machine being improperly accessed and handled by Family Member (FM) 1 resulting in the contamination of ice which could lead to food borne illness for 22 out of 22 residents receiving food from the facility.During an observation on 5/5/26 at 9:19 a.m. the ice machine was observed at the end of the hall, near the kitchen and room [ROOM NUMBER]. The ice machine was observed in a closet with no door. The ice machine was observed with no lock. The ice machine was observed with no signage posted. The ice machine was observed with a designated ice scoop on the right side of the wall.During a concurrent observation and interview on 5/6/26 at 9:33 a.m. at the ice machine, Family Member (FM) 1 was observed exiting Resident 20's room carrying an empty water pitcher. FM 1 then opened the ice machine lid, placed the empty pitcher inside the ice machine, and scooped ice directly from the interior of the ice machine into the pitcher.FM 1 then closed the ice machine lid and returned to Resident 20's room. FM 1 stated he always obtained ice for his mother in this manner and staff had never instructed him not to.During an observation on 5/6/26 at 9:40 a.m. at the ice machine, Dietary Aide (DA) 1 was observed collecting ice with the ice scoop. DA 1 was observed returning to the kitchen with the collected ice.During an interview on 5/6/26 at 9:47 a.m. with DA 1, DA 1 stated she collected ice from the ice machine for kitchen preparation tasks. DA 1 stated there was no lock or door to the ice machine. DA 1 stated all residents, visitors, and staff could potentially access the ice machine at any time. DA 1 stated she had been at the facility for approximately one year and the ice machine had always been in the closet at the end of the hall, near the kitchen and room [ROOM NUMBER], with no door to the closet or lock on the ice machine.During a concurrent observation and interview on 5/6/26 at 10:42 a.m. with the Kitchen Supervisor (KS) at the ice machine, the KS stated the ice machine was accessible to all residents, visitors, and staff. The KS stated the ice machine had always been accessible to all with no doors or locks. The KS stated she had previously observed family members accessing the ice machine improperly. The KS stated she frequently observed FM 1 accessing the ice machine improperly. The KS stated she provided education to family members when she observed improper accessing of the ice machine. The KS stated only facility staff were expected and allowed to access the ice machine to ensure professional standards for food service safety were followed. The KS stated ice should only be scooped with the designated ice scoop and only after hand hygiene was performed to prevent contamination of ice. The KS stated ice would be considered contaminated if ice was scooped with any other object than the ice scoop. The KS stated ice was food and residents were at risk of food borne illness if they encountered contaminated ice. The KS stated the facility did not have any cross-contamination guard rails in place to ensure the ice machine was not contaminated when it was left accessible to all. The KS stated it could not be guaranteed the ice machine was clean and free from contamination at any given time since there was no door or lock to the ice machine to prevent unauthorized access.During an interview with the Director of Nursing (DON) on 5/8/26 at 12:06 p.m. the DON stated ice was food. The DON stated the expectation was for all food items to be stored, handled and served in accordance with standards for food service safety and facility policy for the prevention of foodborne illnesses. The DON stated only staff were allowed to access the ice machine. The DON stated the facility had no barriers in place to prevent unauthorized access to the ice machine to ensure ice was not contaminated by unauthorized users. The DON stated residents were placed at risk for infection and foodborne illness when the ice machine was not secured and was accessible to all.During a record review of the facility's policy and procedure (P&P) titled, Ice Procedures, dated 2023, the P&P indicated, .ice is to be handled properly to prevent infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555347	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Starr Postacute Care	180 Starr Avenue Turlock, CA 95380

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program to help prevent the development and transmission of infections for one of ten sampled residents (Resident 30) when Resident 30 had a midline catheter (thin, flexible tube inserted into a vein in the upper arm used for intravenous treatments) dressing that was not changed for 8 days and then was not labeled or recorded in the medical record accurately after a dressing change.This failure resulted in Resident 30's midline catheter dressing not being changed per provider orders or facility policy and procedures which had the potential to result in catheter-related infections and illness.During an observation on 5/5/26 at 9:53 a.m. with Resident 30, in Resident 30's room, Resident 30's midline catheter dressing was observed dated 4/27/26. Resident 30's midline catheter dressing indicated it had not been changed in eight days.During a record review on 5/5/26 at 4:00 p.m. Resident 30's Treatment Administration Record (TAR), dated 5/5/26, was reviewed. The TAR indicated there were no documented midline catheter dressing changes since admission on [DATE].During an observation on 5/6/26 at 9:20 a.m. with Resident 30, in Resident 30's room, Resident 30's midline catheter dressing was observed dated 5/4/26.During a record review on 5/6/26 at 10:20 a.m. Resident 30's TAR, dated 5/6/26, was reviewed. The TAR indicated the Director of Nursing (DON) documented a midline catheter dressing change on 5/4/26.During a concurrent interview and record review on 5/6/26 at 11:25 a.m. with the Director of Nursing (DON), Resident 30's TAR, dated 5/6/26 was reviewed. The DON stated only Registered Nurses (RN) changed midline catheter dressings within the facility. The DON stated she changed Resident 30's midline catheter dressing on 5/5/26, eight days after the last dressing change on 4/27/26. The DON stated she then documented the incorrect date, 5/4/26, on the midline catheter dressing and TAR. The DON stated Resident 30's midline catheter dressing was required to be changed every 7 days, per physician orders and facility policy. The DON stated it was important to change midline catheter dressings every 7 days, per physician orders and facility policy, to prevent infection. The DON stated it was important to accurately label midline dressings and the TAR to indicate when the next dressing change was due.During an interview on 5/8/26 at 9:54 a.m. with the Infection Preventionist (IP), the IP stated midline catheters were at risk for infections and required weekly dressing changes to maintain the site and prevent catheter related infections associated. The IP stated it was important to accurately document and label midline catheter dressings to maintain weekly dressing change schedules. The IP stated Licensed Vocational Nurses (LVN) were responsible for daily midline catheter dressing assessments. The IP stated LVNs were expected to report if midline catheter dressing changes were due or past due. The IP stated RNs were responsible to change midline catheter dressings and accurately document and label dressing changes.During an interview on 5/8/26 at 12:06 p.m. with the DON, the DON stated facility policy and procedure was not followed when Resident 30's midline catheter dressing was not changed for eight days and then was inaccurately labeled and documented. The DON stated all midline catheter dressings were required to be changed every 7 days to prevent infection and maintain the site.During a record review of Resident 30's document titled, Order Summary Report (OSR), dated 5/6/26, the OSR indicated, .order start date 4/27/26.midline dressing change.every day shift every 7 day(s) and as needed soiled or dislodged.During a record review of the facility's policy and procedure (P&P) titled, Midline Dressing Changes, dated 1/2018, the P&P indicated, .the purpose of this procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings.change midline catheter dressing 24 hours after catheter insertions, every 5-7 days, or if it is wet, dirty, not intact, or compromised in any way.the following information should be recorded in the resident's medical record.date and time dressing was changed.