

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Kings Healthcare & Wellness Center LP		STREET ADDRESS, CITY, STATE, ZIP CODE 851 Leslie Lane Hanford, CA 93230	
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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to Centers for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data by the required deadline. This failure resulted in CMS not knowing how many direct care staff provided daily care and services for 61 residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being. Findings: During an interview and record review on 6/1/2026 at 8:39 a.m. with the Administrator (ADM) and Director of Nursing (DON) during the Facility Entrance Conference, the CMS document titled, Payroll Based Journal (PBJ) Staffing Data Report, dated Fiscal Year (FY) Quarter 1 2026 (October 1 - December 31) was reviewed. The document indicated, .Metric.Failed to Submit Data for the Quarter.Result.Triggered = No Data Submitted for Quarter. The ADM stated the PBJ data was submitted for the wrong quarter. The ADM stated Corporate headquarters notified her that the wrong information was submitted, but it was too late to submit the correct information before the deadline. During an interview on 6/4/26 at 11:25 a.m. with the Payroll Coordinator (PR), the PR stated the PR will input hours into the payroll system and the Corporate Office will pull the payroll information from the system and submit the PBJ information to CMS. The PR stated the Corporate Office will notify the ADM if a reporting quarter was missed. The PR stated the PBJ information should have been submitted to be in compliance with reporting staffing data. During an interview on 6/4/26 at 11:37 a.m. with the ADM, the ADM stated the Corporate Office submitted the wrong information to CMS for the PBJ reporting quarter. The ADM stated the Corporate Office pulls information from the payroll system to submit the PBJ data to CMS. The ADM stated the PBJ data was important to meet the staffing needs of the residents. The ADM stated the Facility Assessment (an assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies) was based off resident diagnoses and the needs of the residents, and the PBJ ensured staffing was in place for the care required for the residents. The ADM stated the PBJ should have been submitted before the reporting deadline. During a review of the professional reference document titled, Staffing Data Submission Payroll Based Journal (PBJ), dated 5/6/26, retrieved from https://www.cms.gov/medicare/quality/nursing-home-improvement/staffing-data-submission, the document indicated, .The Centers for Medicare & Medicaid Services (CMS) has long identified staffing as one of the vital components of a nursing home's ability to provide quality care. CMS has utilized staffing data for a myriad of purposes in an effort to more accurately and effectively gauge its impact on quality of care in nursing homes. We post staffing information on the CMS Nursing Home Compare website, and it is used in the Nursing Home Five Star Quality Rating System to help consumers understand the level and differences of staffing in nursing homes. Section 6106 of the Affordable Care Act (ACA) requires facilities to electronically submit direct care staffing information (including agency and contract staff) based on payroll and other auditable data. The data, when combined with census information, can then be used to report on the level of staff in each nursing home, as well as employee turnover and tenure, which can impact the quality of care delivered.		

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 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 provide care and services in accordance with professional standards of practice for three of 11 sampled residents (Resident 34, Resident 76, and Resident 78) when:1. Resident 34's oxygen therapy (a colorless, odorless, tasteless gas essential to living organisms) was not administered according to the physician order (a set of instructions written by a doctor for clinicians to follow when caring for a resident).This failure resulted in Resident 34 not receiving her oxygen therapy as ordered by the physician, which had the potential to result in shortness of breath, and respiratory distress (difficulty breathing).2. Resident 34's oxygen tubing and nasal cannula (n/c-flexible, clear tube that connects to an oxygen source and placed in the nostrils to deliver oxygen) were not labeled with the date and time and were not stored appropriately when not in use.These failures had the potential for Resident 34 to use a dirty and contaminated nasal cannula and oxygen tubing, which put Resident 34 at risk of infection.3. Resident 78 was administered oxygen therapy without a physician's order or care plan.This failure resulted in Resident 78 receiving unnecessary treatment, which put Resident 78 at risk of nasal dryness, shortness of breath, oxygen toxicity (damage to the lungs that happens from breathing in too much oxygen, which can cause coughing, trouble breathing, and even death in severe cases.4. Resident 76 was a high fall risk and her bed was not in the lowest position.This failure resulted in facility fall protocol not being followed while Resident 76 was lying in bed which could result in accidents, falls or injury. Findings: 1. During a concurrent observation on 6/1/2026 at 10:08 a.m. with Resident 34, in Resident 34's room, Resident 34 was observed dressed, sitting in a wheelchair, wearing an oxygen (O2) nasal cannula. Resident 34's O2 infusion rate was set at 1.5 Liters per minute (L/m - a unit of measurement for oxygen flow rate). Resident stated she had been in the facility since January 2026 due to a fall and was getting physical therapy. During a review of Resident 34's admission Record (AR - a summary of information regarding a patient), dated 6/4/26, the AR indicated Resident 34 was initially admitted to the facility on [DATE] and re-admitted on [DATE] from an acute care hospital with diagnoses of acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), wedge compression fracture of lumbar vertebrae (a break in the front of the spinal bone in the lower back causing the bone to collapse), low back pain, muscle weakness, anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), seizures (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations, or states of awareness), and congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [involving the process of thinking, learning and understanding] and physical functional level assessment), dated 4/16/26, the MDS section C indicated Resident 34 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 13 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 34 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was cognitively intact. During a concurrent interview and record review on 6/3/26 at 2:15 p.m. with Registered Nurse (RN) 1, Resident 34's Order Summary Report (OSR), undated was reviewed. the OSR indicated, .Oxygen 3 liters per minute (LPM) via nasal cannula continuously. RN 1 stated Resident 34's O2 was to be at a 3 L/min rate. During a concurrent observation and interview on 6/3/26 at 2:17 p.m. with RN 1 in Resident 34's room, Resident 34 was observed dressed sitting in a wheelchair in her room wearing O2 tubing. Resident 34's O2 rate was observed to be set at 2.5L/min. RN 1 asked Resident 34 if she changed her O2 rate settings knob, which Resident 34 denied. RN 1 stated the O2 rate was only slightly lower than the physician's order. RN 1 stated Resident 34's O2 rate should have been set at 3 L/min. RN 1 stated it was important to have a physician's order for O2 as it was considered a medication and staff should have followed the order for Resident 34's O2 rate setting. During an interview on 6/3/2026 at 3:15 p.m. with the Director of Nursing (DON) the DON stated staff should have followed the physician orders for Resident 34's O2 rate. The DON stated nurses should check resident's O2 setting every time they went into the resident's room, such as during medication pass and when they checked the residents. During an interview on 6/4/24 at 11:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the nurses checked resident's oxygen. LVN 1 stated there was a monitoring log in the Medication Administration Record (MAR) in the resident's chart. LVN 1 stated physician orders were important so all staff could do their part in caring for the residents. LVN 1 stated even Certified Nursing Assistants (CNA)s could have checked residents on oxygen and told the nurse if they saw a resident with their nasal cannula on their head and not in the nose. 2. During a concurrent observation and interview on 6/03/2026 at 8:31 a.m. in Resident 34's room, Resident 34 was observed sitting on her bed dressed, with her O2 tubing and NC on the floor on the other side of her bed. Resident 34 stated she was waiting for her bath. Resident 34 stated she just took off her NC and dropped it. During a concurrent observation and interview on 6/3/26 at 2:15 p.m. with Resident 34 and RN 1 in Resident 34's room, Resident 34 was observed dressed sitting in wheelchair in her room wearing O2 tubing. Resident 34's tubing was unlabeled with the date and time it was placed on Resident 34. Another labeled O2 tubing and NC was observed on Resident 34's bed. Resident 34 stated she did not know who put the old O2 tubing on her bed, or who placed the new O2 tubing on her. Resident 34 stated someone disconnected her old tubing and connected a different O2 tubing to her tank and took her to therapy. RN 1 stated only RNs were to disconnect and connect residents' O2 tubing. RN 1 stated Resident 34's O2 tubing should have been changed if it was on the floor. RN 1 stated the old tubing should have been thrown away and not put on Resident 34's bed as it was a risk of infection to the resident if it was dirty and was used. RN 1 stated the new tubing should have been labeled so staff knew when to change it. During an interview on 6/3/26 at 2:20 p.m. with the DON, the DON stated only RNs were to connect, disconnect and set resident's O2 rate as it was beyond other staff's scope of practice. The DON stated Resident 34's O2 tubing should have been changed and labeled, and the old tubing should have been thrown away so no one would use it. The DON stated it was a risk of infection to the resident if the dirty O2 tubing was put back on the resident. (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 6/4/2026 at 2:37 p.m. with the DON, the DON stated staff did resident rounds two times a day. The DON stated caring for residents on oxygen was a nursing team effort, but the DON was ultimately responsible for making sure residents on oxygen therapy had the correct setting for the oxygen rate, O2 tubing and NC were labeled and changed weekly or when contaminated. 3. During a concurrent observation and interview on 6/1/2026 at 10:14 a.m. with Resident 78 and Resident 78's Responsible Party (RP - individual authorized to act on a resident's behalf regarding care), in Resident 78's room, Resident 78 was observed dressed, sitting in her wheelchair wearing an O2 nasal cannula with oxygen infusing at 2 L/min. Resident 78 stated she had been in the facility for a while but did not remember why she was in the facility. Resident 78 stated she was unable to remember things. Resident 78's RP stated Resident 78 had been in the facility for one week and had pneumonia. During a review of Resident 78's AR, dated 6/4/26, the AR indicated Resident 78 was admitted from an acute care hospital on 5/20/26 with diagnoses of wedge compression fracture of lumbar vertebrae, fractures of ribs (several breaks in the rib bones), pubis fracture (a break of the ring of bones that connect your spine to the hips), dysphagia (difficulty swallowing), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid). During a review of Resident 78's MDS, dated 5/29/26, the MDS section C indicated Resident 78 had a BIMS score of 3, which indicated Resident 78 was severely cognitively impaired. During a review of Resident 78's MDS, dated 5/29/26, the MDS section O (Special Treatments, Procedures, and Programs) Respiratory Therapy indicated, .number of days this therapy was administered for at least 15 minutes a day in the last 7 days.number of days.7. During a concurrent observation and interview on 6/03/2026 at 10:04 a.m. with Resident 78's RP in Resident 78's room, Resident 78 was observed dressed, in bed, not wearing an O2 NC. Resident 78's RP stated Resident 78 was on O2 therapy while on transport from the hospital to be admitted to the facility. Resident 78's RP stated Resident 78 was no longer using O2. During an interview on 6/3/2026 at 3:00 p.m. with RN 1, RN 1 stated if a resident was admitted to the facility from the hospital on O2, staff checked for O2 discontinuation orders from the hospital and contacted the physician to inform why the resident was using O2 and get orders if the resident was to continue O2 therapy. RN 1 stated there was an emergency such as a resident's O2 was dropping, staff continued giving O2. During an interview on 6/3/2026 at 3:05 p.m. with the DON, the DON stated once the facility received report from the hospital of a new resident on O2 therapy, staff continued the orders on admission and informed the physician for new orders. During a concurrent interview and record review on 6/4/26 at 11:45 a.m. with LVN 1, Resident 78's medical record was reviewed. LVN 1 stated there were no physician orders or care plan for Resident 78's use of O2. LVN 1 stated if a resident was on O2 therapy on admission, and if the hospital's admission orders did not follow the resident from the hospital, staff were to call the physician to receive orders. LVN 1 stated the RNs assessed the residents and administered O2 therapy. LVN 1 (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	high fall risk. LVN 2 stated facility fall protocol interventions were implemented on admission for Resident 76 which included always maintaining the bed in the lowest position to the ground, keeping personal items and the call light within reach, and wearing non-skid footwear. LVN 2 stated it was facility fall protocol and nursing standard of practice to ensure resident beds were maintained in the lowest position, closest to the ground when residents were lying in bed to prevent accidents, falls, or injuries. LVN 2 stated Resident 76 was placed at risk for falls, injuries or worsening of her left arm injury when her bed was in the highest raised position, off the ground, and she was in the bed. During a concurrent interview and record review on 6/4/26 at 9:40 a.m. with the Director of Nursing (DON), facility policy and procedure (P&P) titled, Fall Management Program, dated 11/11/25, and Resident Safety, dated 4/15/21, were reviewed. The DON stated Resident 76 was confused and had a history of falls with injury which made her a high fall risk. The DON stated facility fall protocol interventions included, maintaining the bed in the lowest position to the ground, keeping personal items and the call light within reach, and wearing non-skid footwear. The DON stated facility P&P, facility fall protocol, and nursing standard of practice for safety were not followed when Resident 76 was a high fall risk and her bed was not in the lowest position, closest to the ground, to maintain a safe environment. The DON stated Resident 76 was placed at risk for accidents, falls, and injuries when her bed was elevated, in the highest position, off the ground. During an interview on 6/4/26 at 2:33 p.m. with the DON, the DON stated she completed rounds two times a day on all residents. The DON stated she was responsible for ensuring facility P&P, facility fall protocol and nursing standards of practice for safety were being implemented for all high fall risk residents. During a review of Resident 76'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 6/3/26, the AR indicated Resident 76 was admitted to the facility on [DATE] with diagnoses of metabolic encephalopathy (altered brain function due to an underlying condition), unsteadiness on feet, muscle weakness, dementia (decline in mental ability), altered mental status, and contusion of upper arm (direct impact causing damage to muscle fibers and blood vessels). During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/20/26, the MDS indicated Resident 76 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 9 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 76 was moderately cognitively impaired. During a review of Resident 76's Fall Risk Evaluation, dated 5/15/26, the Fall Risk Evaluation, indicated Resident 76 had a fall risk score of 19. The Fall Risk Evaluation indicated, .if the total score is 10 or greater, the resident should be considered a high risk for potential falls. Prevention protocol should be initiated immediately and documented on the care plan. During a review of Resident 76's Care Plan (CP), dated 5/15/26, the CP indicated, .the resident is at risk for falls [related to] gait/balance problems.fall risk score 19.follow facility fall protocol. During a review of facility policy and procedure (P&P) titled, Fall Management Program, from the (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to ensure one of nine sampled residents (Resident 43) was assessed to safely store and self-administer medication at bedside when Resident 43 had a bottle of [brand name C 1000mg (over the counter vitamin C medication supplement)] medication bottle stored at bedside for self-administration without a physician's order or Medication Self-Administration Assessment Form (MSA- an assessment form to determine if a resident is clinically appropriate to safely and securely store and self-administer their own medication at bedside). This failure resulted in Resident 43 storing and self-administering medications at bedside without nursing oversight which could lead to duplicate drug therapy, adverse medication interactions (when two medications mixed inside the body caused unexpected bad reactions) and unsafe bedside medications storage. During a concurrent observation and interview on 6/1/26 at 10:25 a.m. with Resident 43, in Resident 43's room, Resident 43 was observed sitting on her bed. Resident 43 was observed with [brand name C 1000mg] medication bottle on top of her bedside table. Resident 43 stated [brand name C 1000mg] medication bottle was brought from home, and she had stored the medication bottle at her bedside for some time. Resident 43 stated she took one to two vitamin tablets daily, sometimes up to three tablets per day, depending on what she remembered. Resident 43 stated the facility staff had seen the medication bottle in her room and had never said anything about it. Resident 43 stated the facility staff were aware she was taking the medication and keeping it in her room. During a concurrent interview and record review on 6/3/26 at 2:50 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 43's Order Summary Report (OSR), undated was reviewed. LVN 4 stated Resident 43 did not have a physician's order for Vitamin C or for medication self-administration. LVN 4 stated Resident 43 should have a physician's order and a completed Medication Self-Administration Assessment (MSA) form to store, and self-administered medications. LVN 4 stated Resident 43 was at risk for adverse medication interactions, duplicate therapy, and unsafe medication storage. LVN 4 stated all unlicensed and licensed nursing staff were responsible for identifying medications stored and self-administered at bedside to ensure residents safety. LVN 4 stated Resident 43 had a Brief Interview for Mental Status (BIMS - a standardized screening test used by healthcare professionals to evaluate a resident's cognitive function, memory, and orientation) score of 15 and was alert and able to verbalize needs and concerns. During an interview on 6/4/26 at 12:55 p.m. with the Director of Nursing (DON), the DON stated residents had the right to store and self-administer medications at bedside but required a physician's order and an MSA to ensure the residents could safely store and self-administer their own medications. The DON stated unlicensed and licensed staff were responsible for identifying medications stored and self-administered at bedside. The DON stated the facility's policy and procedures was not followed when Resident 43 had a bottle of [brand name C 1000mg] medication stored at bedside and was self-administering with no physician order and a complete MSA. The DON stated Resident 43 was at potential risk for duplicate therapy, adverse medication interactions and unsafe medication storage. The DON stated she was accountable for all medication administration and safety protocols in the facility. During a review of the facility's policy and procedure (P&P) titled, Medication - Self Administration, dated 8/19/25, the P&P indicated, .Residents have the right to self-administer medications when it is safe and appropriate. Residents will be assessed and monitored for their ability to self-administer medications and must include physician approval, which will be documented in the resident's medical record. The Licensed Nurse completes the Self Administration of Medication Assessment, which evaluates the residents'. Cognitive function. Physical Ability. Medication Knowledge. Knowledge of proper storage and safety. Knowledge of administration of each route.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555485	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Kings Healthcare & Wellness Center LP		STREET ADDRESS, CITY, STATE, ZIP CODE 851 Leslie Lane Hanford, CA 93230	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (CP - a detailed approach to care customized to an individual resident's needs) was developed and implemented for one of three sampled residents (Resident 81), when Resident 81 did not have a care plan for the use of Cervical Collar (C-Collar -a neck brace used to support and immobilize a person's neck) for cervical spinal cord injury (damage to the uppermost part of the spine located in the neck area).This failure had the potential for Resident 81 to not receive the necessary care required for cervical collar, increasing the risk for skin breakdown, improper alignment, and compromised airway. During an observation on 6/1/26 at 9:35 a.m. during initial tour in Resident 81's room, Resident 81 was observed lying in bed, eyes opened, and C-Collar in place. The resident did not answer questions asked.During a review of Resident 81's Face Sheet (FS - a summary of information regarding a resident which includes resident identification, past medical history, care providers, family contact information and other pertinent information), dated 6/4/26, the FS indicated Resident 81 was admitted to the facility on [DATE] with a diagnoses which included Central Cord Syndrome (the most common type of spinal cord injury) at unspecified level of Cervical Spinal Cord (the bundles of nerves running through the neck).During a concurrent interview and record review on 6/3/26 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 81's Order Summary Report (OSR), the OSR indicated . C-collar to neck at all times. start date 6/1/26. LVN 4 stated Resident 81 was admitted on [DATE] and arrived wearing a C-Collar. LVN 4 stated Resident 81 did not have a care plan in place for the C-Collar upon admission and a care plan should have been initiated at the time of admission. LVN 4 stated the importance of having a care plan in place upon admission for a C-Collar was to ensure continuity of care and to provide facility staff with guidance on how to properly care for Resident 81and manage the C-Collar. LVN 4 stated it was important to monitor the C-Collar to prevent skin breakdown, ensure comfort and proper fit, and maintain safety precautions while Resident 81 was wearing the C-Collar.During an interview on 6/4/26 at 12:41 p.m. with the Director of Nursing (DON), the DON stated a care plan for the C-Collar should have been started upon admission. The DON stated the nurse developed the care plan based on the resident's assessment and needs. The DON stated the purpose of the C-Collar care plan was to monitor the residents' condition and ensure the provision of proper and safe care for both the residents and staff. The DON stated the absence of a C-Collar care plan may increase the risk of complications, such as neurological injuries. The DON stated it was her responsibility to ensure the residents' care plans are updated and are being implemented by facility staff.During a review of facility's policy and procedures (P&P) titles, Person- Centered Care Planning, effective date 5/22/26, the P&P indicated, . The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. The facility must develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights, that includes measurable objectives, and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure daily nurse staffing information contained all required information when the total number and actual hours worked by Registered Nurses (RN), Licensed Vocational Nurses (LVN), and Certified Nursing Assistants (CNA) were not posted for 61 residents and visitors to view. This failure resulted in 61 residents and visitors not knowing how many direct care hours were actually provided daily for each resident by licensed and unlicensed staff. Findings: During an observation on 6/03/26 at 12:23 p.m. a facility document titled, [NAME] HealthCare and Wellness Center Staffing Information (Staffing Information), dated 6/3/26 was observed posted in the hallway. The document did not indicate if the posted hours were anticipated or actual hours worked by licensed and non-licensed staff. During an interview on 6/3/2026 at 3:27 p.m. with the Director of Staff Development (DSD) the DSD stated she was responsible for staff scheduling and completing the Staffing Information form. The DSD stated she scheduled staff based on the needs and acuity of the residents. During an interview and record review on 6/4/26 at 11:14 a.m. with the DSD, the facility's Staffing Information document was reviewed. The DSD stated the posted document was the anticipated hours of licensed and non-licensed patient care staff. The DSD stated she did not use the CDPH 612 form titled, Census and Direct Care Service Hours Per Patient Day (DHPPD) for the breakdown of patient care hours for CNAs and nurses. The DHPPD form, dated 6/2/26 was reviewed. The DSD stated payroll fills out the DHPPD form with documented actual hours of nurses and CNAs. During an interview and record review on 6/4/26 at 11:25 a.m. with the Payroll (PR) coordinator, the DHPPD form dated 6/2/26 was reviewed. The PR stated she completed the form the next day after the night shift hours were calculated and kept the forms in a binder. The PR stated the DHPPD information was important to be sure the facility was in compliance with scheduling staff according to the facility census. The PR stated not having enough staff can affect direct care hours for the residents. During an interview on 6/4/2026 at 2:37 p.m. with the Director of Nursing (DON), the DON stated completing the DHPPD form was important, so residents and visitors were aware of staff hours and the census. The DON stated during standup report, she told staff what the staffing hours and census numbers were for the day. The DON stated she was responsible for the accurate daily posting of licensed and non-licensed staffing hours. During a review of the facility's policy and procedure (P&P) titled, Nursing Department - Staffing, Scheduling & Postings, dated 7/2018, the P&P indicated, .to ensure that adequate number of nursing personnel are available to meet resident needs. the Facility will employ Nursing Staff that will be on duty in at least the number and with the qualifications required to provide the necessary nursing services for residents admitted for care. in staffing an adequate number of nursing service personnel, scheduling will be done as needed to meet resident needs, and such information will be posted as required. the Facility will post the following information on a daily basis. the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. Registered Nurses. Licensed Vocational Nurses. Certified Nurse Aides. Resident Census. the Facility will post the nurse staffing data specified above, on a daily basis at the beginning of each shift. During a review of the facility job description document titled, Director of Nursing Services, undated, the document indicated, .under the direction of the Administrator, the Director of Nursing Services is responsible for the administration and management of Nursing services to residents in accordance with orders of the physicians and total needs of the residents. assumes ultimate responsibility for coordinating plans for the total care of each resident which comply with physician's orders, governmental regulations, and facility resident care policies. assists in controlling nursing service hours. assures adequate 24-hour nursing coverage in the facility each day. During a review of the facility job description document titled, Director of Staff Development, undated, the document indicated, .oversee monthly schedule and daily assignments for all CNA's. post Daily (continued on next page)		

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

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staffing Projected NHPPD Hours.review Daily Staffing, PPD/Overtime to ensure required minimum hours are met.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility failed to provide pharmaceutical services to ensure controlled substance medications (is a drug that is strictly regulated by the government because of high risk of misused and abused) are administered and recorded accurately in accordance with the facility's policies and procedures for one of two sampled residents (Resident 39) when Licensed Vocational Nurse (LVN) 2 failed to accurately document Resident 39's controlled substance medication on the controlled substance log to accurately reflect the controlled substance administration. This failure placed Resident 39 at potential risk for medication errors, duplicated dosing and undetected controlled substances diversion (theft or illegal redirecting of a regulated drug). During a medication administration observation on 6/3/26 at 8:28 a.m. with Licensed Vocation Nurse (LVN)2 in Resident 39's room, Resident 39 was lying in bed, with facial grimacing and moaning. LVN 2 left Resident 39's room and prepared pain medication from the medication cart. LVN 2 prepared Morphine Sulfate (a controlled medication concentrate oral solution used to treat moderate-to-severe pain). The prescribed dose was 0.5ml [milligrams - unit of measurement], equivalent to 10mg [milligrams - unit of measurement], to be administered orally every 4 hours as needed for moderate pain. LVN 2 administered the medication to Resident 39. LVN 2 documented the medication on the Individual Narcotic Record (INR - a log used by healthcare facilities to track the receipt, administration, and disposal of controlled medication), sheet for Resident 39. LVN 2 documented the administration of Morphine Sulfate 0.5ml on the routine INR sheet instead of on the designated as-needed INR sheet. During a concurrent interview and record review on 6/3/26 at 8:40 a.m. with LVN 2, Resident 39's INR sheet undated was reviewed. The INR sheet for Routine Morphine Sulfate indicated, at 8:34 a.m., LVN2 documented the administration of Morphine Sulfate 0.5 ml orally every 4 hours as needed. LVN 2 stated Morphine Sulfate 0.5ml was administered as needed and not routinely. LVN 2 stated there were two separate INR sheet: one INR for Routine Morphine Sulfate 0.5ml administered orally every 6 hours, and another INR for as-needed Morphine 0.5 ml administered orally every 4 hours as needed for pain. LVN 2 signed the INR sheet for Routine Morphine Sulfate 0.5ml administered orally every 6 hours instead of the INR as-needed Morphine Sulfate 0.5ml administered orally every 4 hours as needed for pain. LVN 2 stated, I should have signed on the Morphine Sulfate every 4 hours as needed narcotic record and not on the Morphine sulfate every 6 hours routine narcotic record. LVN 2 stated incorrect signing on the narcotic log could cause medication discrepancies and potentially lead to medication errors. During a review of Resident 39's Order Summary Report (OSR) dated 6/4/26, the OSR indicated, .Morphine Sulfate (Concentrate) Oral Solution . Give 0.5 ml by mouth every 4 hours as needed for Moderate Pain . Morphine Sulfate (Concentrate) Oral Solution . Give 0.5ml by mouth every 6 hours for CHRONIC PAIN. During an interview on 6/4/26 at 11:05 a.m. with the Director of Nursing (DON), the DON stated the nursing staff were expected to accurately sign the INR. The DON stated that if a narcotic was administered routinely, it should have been documented on the routine INR, and if the narcotic was administered on an as-needed basis, it should have been documented on the as-needed INR. The DON stated the improper narcotic documentation could have created medication discrepancies, potentially lead to medication errors, and placed resident safety at risk. The DON stated it was her responsibility to ensure the accuracy and compliance of narcotic documentation within the facility. During a review of the facility's policy and procedure (P&P) titled, MEDICATION ADMINISTRATION, dated 3/2026, the P&P indicated, .When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): Date and time of administration, Amount administered, Signature of the nurse administering the dose, completed after the medication is actually administered.		

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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. Based on observation, interview, and record review, the facility failed to ensure food was stored and served safely in accordance with professional standards of food service safety for 57 out of 57 residents eating at the facility when 4 single serve pre-prepared ice cream cups and an opened box of kielbasa rope sausage were in the freezer past the use by date. This failure resulted in food items being retained past the use by date which could lead to the serving of expired food items and foodborne illness. During a concurrent observation and interview on 6/1/26 at 9:02 am with the Certified Dietary Manager (CDM), in the kitchen, 4 single serve pre-prepared ice cream cups were observed with a use by date of 5/29/26. The label indicated the 4 single serve pre-prepared ice cream cups were 3 days past the use by date. An opened box of kielbasa rope sausage was observed with a use by date of 5/22/26. The label indicated the opened box of kielbasa rope sausage were 10 days past the use by date. The CDM stated all kitchen staff were expected to accurately and correctly label all food items with a received, opened and use by date. The CDM stated all kitchen staff were expected to discard food items by the labeled use by date. The CDM stated food items retained past the use by date were considered expired and needed to be removed from the kitchen to prevent accidental serving of expired food which could lead to foodborne illness. During an interview on 6/3/26 at 8:33 a.m. with the Registered Dietitian (RD), the RD stated all food items were expected to be accurately and correctly labeled by kitchen staff with a received, opened and use by date. The RD stated it was important to adhere to labeled use by dates to prevent the serving of expired food items. The RD stated serving expired food items could result in loss of palatability and/or foodborne illness. During an interview on 6/4/26 at 9:40 a.m. with the Director of Nursing (DON), the DON stated kitchen staff were expected, per food safety standards of practice and facility policy, to correctly and accurately label all food items with a received, opened and use by date. The DON stated kitchen staff were expected, per food safety standards of practice and facility policy, to remove food items from the kitchen by the use by date to prevent serving of expired food items which could result in foodborne illness. The DON stated standards of food safety standards of practice and facility policy were not followed when the kitchen freezer contained 4 single serve pre-prepared ice cream cups 3 days past the use by date and an opened box of kielbasa rope sausage were 10 days past the use by date. During an interview on 6/4/26 at 2:33 p.m. with the DON, the DON stated she completed monthly kitchen audits. The DON stated she was responsible for ensuring kitchen staff followed facility policy and procedure. During a review of the facility's document titled, Diet Type Report, dated 6/4/26, the document indicated 57 residents received food from the facility kitchen. During a review of the facility's kitchen in-service training document titled, Labeling/Dating/Expired Products, dated 3/21/26, the document indicated, .how to label/date items:.receive date.opened date.expiration date from receive date (may not use manufacturers).use by date from opened date (be sure use by date does not go past manufacturers date).all shifts should check for expired items daily throughout the shift. Any items that are to be found expired should be discarded immediately.every shift is responsible for expired or not labeled items.it is the dietary department's responsibility to ensure all items are correctly stored. If items are found to be mislabeled, it is your responsibility to correct or discard them as necessary.everyone in the department is liable for the correct storage of all items in the dietary department. During a review of the facility's kitchen in-service training document titled, Empower Employees Through Food Safety Training, dated 3/21/26, the document indicated, .labeled with a use-by date seven days from when the food was first thawed, opened, or prepared. The day that the food was opened or prepared counts as day one.foods should be labeled with the earliest use-by date of any of its ingredients. If a food is not served or sold before its use-by date, it must be thrown away.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program to help prevent the development and transmission of infections when, two of two licensed nurses (Licensed Vocational Nurse [LVN] 3 and LVN 4), failed to follow the manufacturer's instructions for use (IFU- the official step by step directions provided by the maker of a product) by not maintaining the required germicidal disposable wipes dwell time (the exact amount of time a disinfectant must stay visibly wet on a surface to completely kill germs) during the disinfection (chemical process that kills harmful germs) of a glucometer (a medical device used for determining the amount of sugar in the blood) after use on Resident 13, Resident 21, Resident 40, Resident 65, and Resident 85. This failure had the potential to result in the spread and transmission of communicable (infectious disease - a condition that can be transmitted from one person to another through various means including direct contact and indirect contact) diseases and blood born infections (viruses that are carried in the blood) among residents in the facility. During an observation on 6/3/26 at 11:20 a.m. outside Resident 40's room, LVN 3 was observed gathering supplies to perform a blood glucose test (a method of measuring the concentration glucose [sugar] in the blood) on Resident 40. After obtaining a blood sample from Resident 40, LVN 3 was observed using one germicidal wipe (a germicidal [kills germs] disposable wipe used for disinfecting surfaces) to clean the glucometer. The glucometer was placed on the medication cart and allowed to air-dry. LVN 3 was observed setting a two-minute timer. The glucometer was observed to be dry within one minute after being cleaned with the germicidal wipe by LVN 3. The glucometer did not remain wet for two minutes. During an observation on 6/3/26 at 11:27 a.m. outside Resident 21's room, LVN 3 was observed gathering supplies to perform a blood glucose test on Resident 21. After obtaining a blood sample from Resident 21, LVN 3 was observed using one germicidal wipe to clean the glucometer. The glucometer was placed on the medication cart and allowed to air-dry. LVN 3 was observed setting a two-minute timer. The glucometer was observed to be dry within one minute after being cleaned with the germicidal wipe by LVN 3. The glucometer did not remain wet for two minutes. During a concurrent observation and interview on 6/3/26 at 11:30 a.m. with LVN 3, outside Resident 13's room, LVN 3 was observed gathering supplies to perform a blood glucose test on Resident 13. After obtaining a blood sample from Resident 13, LVN 3 was observed using one germicidal wipe to clean the glucometer. The glucometer was placed on the medication cart and allowed to air-dry. LVN 3 was observed setting a two-minute timer. The glucometer was observed to be dry within one minute after being cleaned with the germicidal wipe by LVN 3. LVN 3 stated she cleaned the glucometer with one (brand name) germicidal wipe after resident use and allowed the glucometer to air-dry for two minutes. LVN 3 stated the glucometer did not remain wet for two minutes. During an observation on 6/3/26 at 11:41 a.m. with LVN 4, outside Resident 85's room, LVN 4 was observed gathering supplies to perform a blood glucose test on Resident 85. After obtaining a blood sample from Resident 85, LVN 4 was observed using one germicidal wipe to clean the glucometer. The glucometer did not remain wet for two minutes. During an observation on 6/3/26 at 12:26 p.m. with LVN 4, outside Resident 65's room, LVN 4 was observed gathering supplies to perform a blood glucose test on Resident 65. After obtaining a blood sample from Resident 65, LVN 4 was observed using one germicidal wipe to clean the glucometer. The glucometer did not remain wet for two minutes. During a concurrent interview and record review on 6/3/26 at 2:51 p.m. with the Infection Preventionist (IP), the glucometer manufacturer guidelines titled, [brand name] Blood Glucose Monitoring System Quality Assurance/ Quality Control Reference Manual, undated, and the germicidal wipes manufacturer's instructions titled, General Guidelines For Use [brand name] Germicidal Disposable Wipe, undated, were reviewed. The IP stated glucometers were expected to be cleaned and disinfected, per glucometer and germicidal wipe manufacturer guidelines, after use on each resident, to prevent the spread of communicable diseases and blood-borne pathogens. The IP stated the germicidal wipe manufacturer (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	guidelines indicated the glucometer required a two-minute wet time (the amount of time the item needs to remain visibly wet in order to kill specific bacteria) to ensure disinfection. During an interview on 6/3/26 at 3:23 p.m. with the IP and the Director of Nursing (DON), the IP stated one germicidal wipe was used to clean the glucometer, a second germicidal wipe was used to disinfect the glucometer and then a two-minute timer would be started to monitor and ensure a two-minute wet time, after disinfection. The IP stated the glucometer began to dry at the one-minute mark and required a third germicidal wipe to maintain a two-minute wet time. The IP stated after maintaining a two-minute wet time on the glucometer, the glucometer was then air dried before use. The DON stated the glucometer needed to remain wet for two minutes to be sure it killed germs on the glucometer and did not contaminate the next resident it was used on. During an interview on 6/4/26 at 9:40 a.m. with the DON, the DON stated nursing staff had not followed manufacturer guidelines or facility policy and procedure when only one germicidal wipe was used to clean the glucometer. The DON stated nursing staff did not disinfect the glucometer or maintain a two-minute wet time. The DON stated nursing staff did not properly clean and disinfect the glucometer between resident use which could result in the spreading of communicable diseases and blood-borne infections. During a review of the facility's lesson plan titled, Disinfecting Blood Glucometers, dated 12/22/25, the lesson plan indicated, .maintain wet contact time according to facility policy/manufacturer instructions; allow to dry. During a review of the facility's policy and procedure (P&P) titled, Infection Control-Policies & Procedures, dated 1/1/12, the P&P indicated, .facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of disease and infections. During a review of the glucometer manufacturer's instructions titled, [brand name] Blood Glucose Monitoring System Quality Assurance/ Quality Control Reference Manual, undated, the manufacturer's instructions indicated, .to minimize the risk of transmitting blood-borne pathogens, the cleaning and disinfecting procedure should be performed as recommended in the instructions below. The [brand name] Glucose Monitoring System may only be used for testing multiple patients when standard precautions and the manufacturer's disinfecting procedures are followed. The meter should be cleaned and disinfected after use on each patient. The cleaning procedure is needed to clean dirt, blood and other bodily fluids off the exterior of the meter before performing the disinfecting procedure. The disinfecting procedure is needed to prevent the transmission of blood-borne pathogens. please read the manufacturer's instructions before using their wipe on the meter. many wipes act as both a cleaner and disinfect. If blood is visibly present on the meter, two wipes must be used, one wipe to clean and a second wipe to disinfect. treated surface must remain wet for recommended contact time. Please refer to wipe manufacturer's instructions. During a review of the germicidal wipe manufacturer's instructions titled, General Guidelines For Use [brand name] Germicidal Disposable Wipe, undated, the manufacturer's instructions indicated, .allow treated surface to remain wet for two (2) minutes. Let air dry.		