

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Palm Village Retirement Comm.		STREET ADDRESS, CITY, STATE, ZIP CODE 703 W Herbert Ave Reedley, CA 93654	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained dignity and respect for one of three sampled residents (Resident 8) when Resident 8's urinary catheter (flexible tube inserted into bladder to drain urine) bag was uncovered and visible to other residents and visitors. This failure had the potential to compromise Resident 8's dignity and privacy by exposing their foley catheter bag, leading to embarrassment or psychosocial harm. During a review of Resident 8's admission Record (AR) dated 7/25/25, the AR indicated, Resident 8 was initially admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow movements), diabetes mellitus (condition that happens when your blood sugar is too high), obstructive and reflux uropathy (obstructive and reflux uropathy), and malignant neoplasm of the prostate (a cancerous tumor in the prostate gland). During a review of Resident 8's Order Summary Report (OSR) dated 7/17/25, the OSR indicated, .foley catheter 20F.to gravity drainage. Change PRN (as needed or requested) for plugging/leaking/dislodging as needed. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/21/25, the MDS section C indicated Resident 8 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 8 was cognitively intact. During an observation on 7/22/25 at 9:58 a.m. in Resident 8's room, Resident 8's foley catheter was not covered by a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag, so it is not visible). During a concurrent observation and interview on 7/24/25 at 1:44 p.m. with Licensed Vocational Nurse (LVN) 1, a photograph taken on 7/22/25 showing the uncovered Foley catheter bag of Resident 8, was shown to LVN 1. Upon review, LVN 1 confirmed the foley catheter bag was not covered with a dignity bag. LVN 1 stated, the foley catheter drainage bag should have been covered. During an interview on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), the DON stated, she expected Resident 8's foley catheter bag to be covered with a dignity bag. The DON stated, a dignity bag always needed to cover the foley catheter bag. The DON stated, not having a dignity bag violated Resident 8's dignity, and privacy regulation. The DON stated, the dignity bag needed to be provided so other residents would not know Resident 8's condition. During a review of the facility's policy and procedure (P&P) titled, Quality of Life-Dignity, dated 08/19, the P&P indicated, . Residents are treated with dignity and respect at all times. Staff shall promote dignity. Helping the residents to keep urinary catheter bags covered.</p>

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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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>(continued on next page)</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to provide residents with accessibility to file anonymous grievances or complaints and did not update the grievance policy to ensure the prompt resolution of grievances for three out of 12 sampled residents (Resident 41, Resident 100, and Resident 112) when:1. Resident 41, Resident 100, and Resident 112 did not know how to file a grievance anonymously.2. The facility's policy and procedure (P&P) titled Palm Village Health Care Center Grievances Policy was not updated to ensure the residents were informed of their right to submit grievances anonymously.This failure placed residents at risk of deterrence from reporting concerns, limited access to grievance resolution, and infringement upon their rights to concerns without fear of identification or reprisal.Findings:1. During a concurrent observation and interview on 7/24/25 at 3:00 p.m. with Resident 41, Resident 100 and Resident 112 in Resident Council meeting, Resident 41 stated he did not know how to file a grievance anonymously. Resident 100 and Resident 112 also stated they did not know how to file a grievance anonymously, while the remaining members of the Resident Council remained silent.During an interview on 7/24/25 at 3:00 p.m. with Resident 41, in Resident council meeting, Resident 41 stated the Grievance Official was Social Service Director (SSD) personnel. Resident 41 stated SSD would give them the form to fill out and it was to be returned to SSD. During a review of Resident 41's admission Record (AR) dated 7/25/25, the AR indicated, Resident 41 was initially admitted to the facility on [DATE].During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/24/25, the MDS section C indicated Resident 41 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 41 was cognitively intact.During a review of Resident 100's AR dated, the AR indicated, . Resident 100 was admitted to the facility on [DATE] .During a review of Resident 100's MDS Assessment, dated 7/17/2025, the MDS Assessment indicated Resident 100's BIMS score of 15 indicating Resident 100 was cognitively intact.During a review of Resident 112's AR dated, the AR indicated, . Resident 112 was admitted to the facility on [DATE] .During a review of Resident 112's MDS Assessment, dated 6/25/2025, the MDS Assessment indicated Resident 112's BIMS score of 15 indicating Resident 112 was cognitively intact.During a concurrent observation and interview on 7/24/25 at 3:30 p.m. with the SSD, in the SSD office located at the front entrance across the hall from the receptionist front desk, the SSD stated he was also the grievance coordinator. The SSD stated residents can request a grievance form from staff, the forms were in the social services office as well as each of the nurses' stations. The SSD stated once completed, the residents were required to return the form to the staff. The SSD acknowledged there was no drop box available and no system in place to allow residents to submit grievances anonymously. The SSD stated if a resident did not want anyone to know, the residents could speak with him privately in the office. The SSD added once a grievance was received, they addressed the issue, such as talking to the involved staff, but without telling them who submitted the grievance. The SSD acknowledged that was not an adequate submission of an anonymous grievance, and stated No, that is not anonymous, and I can see how it could make someone feel uncomfortable. During a concurrent observation and interview 7/24/25 at 3:35 p.m. with Medical Records (MR), outside of the medical records office located at nurses' station in [NAME] wing, MR stated the residents are required to request the grievance form. MR was unable to find the grievance form in the [NAME] wing nurses' station. MR stated the forms should be in the file cabinet at the nurses' station.During an interview on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), the DON stated residents could request and complete grievance forms and submit them to social services or the administration. The DON stated although concerns could be addressed during resident council, there was no established way to follow up anonymously, and the facility did not have a consistent process without staff knowing who submitted them. The DON acknowledged there was no formal system to support anonymous reporting.2. During an interview on 7/24/25 at 3:30 p.m. with the SSD, the SSD provided the facility policy titled, Palm Village Healthcare Center Grievance Policy. The SSD stated he also served as the facility's grievance official. The policy was reviewed and did not include procedure to inform residents of their right to submit grievances anonymously. The policy did not include language describing how anonymous grievances could be submitted or protected During a review of the facility's P&P titled, Palm</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set Assessment (MDS- MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for three of eight sampled residents (Resident 1, Resident 10, and Resident 73) when: 1.Resident 1's fall and surgery was inaccurately coded in MDS assessment. This failure had the potential to result in Resident care needs not met and the potential for additional fall and injury. 2.Resident 10's restraints were inaccurately coded in the quarterly MDS assessment. This failure had the potential to result in incorrect treatments provided to Resident 10 due to inaccurate assessments.3.Resident 73's restraints were inaccurately coded in the quarterly MDS assessment. This failure had the potential to result in incorrect treatments provided to Resident 73 due to inaccurate assessments.Findings:</p> <p>1. During a concurrent observation and interview on 7/22/25 at 9:30 a.m. in Resident 1's room, Resident 1 was observed sitting at bedside with spouse. Resident 1 was appropriately dressed and stated she was not sure when she was admitted to the facility. Resident 1 stated she had a fall and had broken her hip and was working with therapy but developed respiratory complications and had to return to the hospital.</p> <p>During a review of Resident 1's admission Record (AR-a document containing resident profile information), dated 7/25/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included Fracture of Unspecified part of neck of left femur (break in the upper part of the thigh bone near the hip joint) and pneumonia (inflammation in the lungs).</p> <p>During a concurrent interview and record review on 7/25/25 at 11:05 a.m. with admission Coordinator/Minimum Data Set Nurse (AC/MDSN), the AC/MDSN reviewed Resident 1's five day MDS assessment dated [DATE] section J (Health Conditions), Resident 1's history of fall and surgery was not coded in the MDS assessment. The AC/MDSN stated the assessment in Section J Fall History and Prior Surgery was not coded accurately. The AC/MDSN stated Resident 1's original admission was on 5/6/25 due to a fall with fracture and was admitted in general acute care hospital (GACH) to repair the fracture. The AC/MDSN stated she did not code Resident 1 as having history of fall and surgery. The AC/MDSN stated she should have coded Resident 1 had a history of fall and had surgery. The AC/MDSN stated it was her responsibility to ensure MDS assessments were accurate.</p> <p>During an interview on 7/29/25 at 11:56 a.m. with the Director of Nursing (DON), the DON stated she had the oversight of the MDSN. The DON stated her expectation was to ensure resident records are reviewed, interview staff and residents and complete their assessments in MDS. The DON stated her expectation was for each staff completing MDS assessment including the AC/MDSN to ensure accuracy of their assessments.</p> <p>During an interview on 7/29/25 at 2:45 p.m. with the Administrator (ADM), the ADM stated her expectation was for the MDS assessments to be completed and accurately coded. The ADM stated each staff completing the MDS assessments are responsible in ensuring accurate assessments when completing the MDS.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of facility's policy and Procedure (P&P) titled, Resident Assessment Instrument [RAI] dated 10/19, the P&P indicated, .Providing care to residents with post-hospital and long-term care needs is complex and challenging work. Clinical competence, observational, interviewing and critical thinking skills, and assessment expertise from all disciplines are required to develop individualized care plans . The RAI helps nursing home staff look at residents holistically--as individuals for whom quality of life and quality of care are mutually significant and necessary .</p> <p>During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 10/24, indicated. Definitions .Fall unintentional change in position coming to rest on the ground, floor or onto the next lowest surface [e.g., onto a bed, chair, or bedside mat]. The fall may be witnessed, reported by the resident or an observer or identified when a resident is found on the floor or ground . Steps for Assessment. The period of review is 180 days [6 months] prior to admission . Code 1, yes if resident or family report or transfer records and medical records document a fall in the 2-6 months prior to the resident entry date . Steps for Assessment: 1. Ask the resident and their family member or significant other about any surgical procedures in the 100 days prior to admission. 2. Review the resident's medical record to determine whether the resident had major surgery during the 100 days prior to admission . Code 1, Yes: if the resident had major surgery during the 100 days prior to admission .</p> <p>2. During a review of Resident 10's &ldquo;admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes),&rdquo; dated 7/24/25, the &ldquo;AR&rdquo; indicated, Resident 10, was admitted to the facility on [DATE] with diagnoses which included: &ldquo;Unspecified dementia (a progressive state of decline in mental abilities), history of falling, other reduced mobility, depression (persistent sadness, loss of interest in activities and difficulty with relationships impacting a person&rsquo;s thinking and behavior), muscle weakness generalized&hellip;&rdquo;.</p> <p>During a concurrent observation and interview on 7/24/25 at 8:30 a.m. with Resident 10 in the dining room, Resident 10 was sitting in his wheelchair having breakfast. Resident 10 was unable to respond to any questions asked. There were no restraints or alarms noted on Resident 10.</p> <p>During a concurrent interview and record review on 7/24/25 at 10:15 a.m. with admission Coordinator/Minimum Data Set Nurse (AC/MDSN), Resident 10&rsquo;s &ldquo;Minimum Data Set&rdquo; (MDS- resident assessment tool which indicated physical and cognitive abilities), dated 4/30/25 was reviewed, the &ldquo;MDS&rdquo; section P indicated, Resident 10's Restraints and Alarm status under &ldquo;used in chair or out of bed was Other- 1&rdquo; (0 indicates not used, 1 indicates used less than daily, 2 indicates used daily). The AC/MDSN stated Resident 10 did not use any restraints or alarms. The AC/MDSN stated it was an error and that it would need to be removed.</p> <p>During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with the Director of Staff Development (DSD), Resident 10&rsquo;s &ldquo;MDS&rdquo; dated 4/30/25 was reviewed. The DSD stated Resident 10 was not on any restraints or alarms. The DSD stated the MDSN was responsible for the accuracy of assessment on residents.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/29/25 at 11:05 a.m. with the Director of Nursing (DON), Resident 10's MDS dated 4/30/25 was reviewed. The DON stated Resident 10 was not on any restraints or alarms. The DON stated it was a mistake. The DON stated the MDSN needed to code correctly. The DON stated the MDSN coordinator is expected to assess the resident, review the resident condition accurately, then document accurately. The DON stated documenting accurately is important because it reflects the resident condition. The DON stated that when assessments are not documented accurately it suggests residents are receiving treatments that differ from prescribed orders.</p> <p>During a review of the facility's document titled, "Job Description, MDS Coordinator," dated 2/2016, the document indicated "Purpose: The primary purpose of the MDS Coordinator is to conduct and coordinate the development and completion of the resident assessment in accordance with State and Federal guidelines, policies, and regulations that govern this facility."</p> <p>During a review of professional reference titled, CMS's RAI Version 3.0 Manual dated 10/19, the reference indicated. Chapter 1: Resident Assessment Instrument (RAI) 1.1 Overview. The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care 1.2 Content of the RAI for Nursing Homes The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status</p> <p>3. During observation on 7/23/25 at 8:50 a.m. Resident 73's room was observed to be well organized, and a green bed sensor alarm was clearly observed from the doorway.</p> <p>During a review of Resident 73's admission Record (AR) dated 7/25/25, the AR indicated, Resident 73 was initially admitted to the facility on [DATE] with a diagnosis of Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), Exudative age-related macular degeneration [AMD], is a severe form of AMD characterized by the growth of abnormal blood vessels under the retina, which can leak fluid and blood, leading to vision loss), and sensorineural hearing loss (a type of hearing loss that occurs when there is damage to the inner ear or the auditory nerve, which carries sound signals to the brain, most common type of permanent hearing loss.)</p> <p>During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/9/25, the MDS section C indicated Resident 73 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 12 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 73 was moderately impaired.</p> <p>During a concurrent interview and record review on 7/24/25 at 1:44 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 73's Care Plan (CP) and Order Summary Report (OSR) dated 7/24/25 was reviewed. LVN 1 validated the OSR indicated bed sensor alarm was active and was placed on 11/12/24. LVN 1 confirmed the CP was in place and dated 11/12/24. LVN 1 stated Resident 73 did have a bed sensor alarm on.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/24/25 at 4:11 p.m. with the Minimum Data Set Nurse (MDSN), Resident 73's Minimum Data Set (MDS) section P on restraints and alarms, dated 1/8/25, was reviewed. The MDS section P indicated that bed alarms were not used. The MDSN stated that she was responsible for completing the MDS assessment and validated that Resident 73's MDS section P did not accurately reflect Resident 73's active orders and care plan (CP) to have used a bed sensor alarm. The MDSN mentioned that she was supposed to review Resident 73's CP and provider's orders during a quarterly assessment. She emphasized the importance of reviewing and communicating with the floor nurses to ensure an accurate assessment of the residents and to document the correct code for the residents. The MDSN confirmed that Resident 73's MDS section P - Bed alarm was modified on 7/23/25 to reflect that it was used daily.</p> <p>During an interview on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON) the DON stated it was the expectation the MDSN ensured the MDS reflected Resident 73's current care needs. The DON stated she expected the MDSN to conduct the assessments timely and to have followed the calendar due date. The DON stated it was the Responsibility of the MDSN to have confirmed the accuracy of section P for Resident 73. The DON stated the code on the MDS should have reflected the use of the bed alarm.</p> <p>During a review of the facility's document titled, "Job Description, MDS Coordinator," dated 2/2016, the document indicated "Purpose: The primary purpose of the MDS Coordinator is to conduct and coordinate the development and completion of the resident assessment in accordance with State and Federal guidelines, policies, and regulations that govern this facility."</p> <p>During a review of professional reference titled, CMS's RAI Version 3.0 Manual dated 10/19, the reference indicated. Chapter 1: Resident Assessment Instrument (RAI) 1.1 Overview. The purpose of this manual is to offer clear guidance about how to use the Resident Assessment Instrument (RAI) correctly and effectively to help provide appropriate care 1.2 Content of the RAI for Nursing Homes; The RAI process has multiple regulatory requirements. Federal regulations at 42 CFR 483.20 (b)(1)(xviii), (g), and (h) require that (1) the assessment accurately reflects the resident's status</p>		

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<p>F 0644</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a new Preadmission screening and Resident Review (PASARR- a federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) level 1 screening for one of five sampled residents (Resident 2) when Resident 2's PASARR level 1 dated 5/14/25 completed prior to admission to the facility did not include diagnosis of anxiety (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with daily activities) and use of psychotropic medications (drugs that affect the mind, emotions, and behavior). This failure had the potential for Resident 2 to not receive the appropriate services related to her diagnosis and medication used. Findings: During a concurrent observation and interview on 7/23/25 at 8:35 a.m. in Resident 2's room, Resident 2 was observed sitting up in wheelchair at bedside eating breakfast with staff assistance. Resident 2 stated he had been in the facility for almost a year because his wife was also in the facility as a resident. During a review Resident 2's admission Record (AR-a document containing resident profile information), dated 7/25/25, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnoses which included anxiety, dementia (a progressive state of decline in mental abilities) and Alzheimer's disease (disease characterized by a progressive decline in mental abilities). During a review of Resident 2's Order Summary Report [OSR], dated 7/29/25, the OSR indicated, . Lorazepam [medication used to treat anxiety] Oral Tablet one [1] milligram [MG- unit of measurement] . Quetiapine Fumarate [medication used to treat dementia] Oral Tablet 50 MG . Give 1 tablet by mouth at bedtime . During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with admission Coordinator/Minimum Data Set Nurse (AC/MDSN), the AC/MDSN reviewed Resident 2's PASARR level I assessment dated [DATE]. The AC/MDSN stated the level I PASARR assessment was completed in general acute care hospital (GACH) prior to Resident 2's admission to the facility on 5/25/25. The AC/MDSN stated Resident 2 was admitted with a diagnosis of anxiety and was prescribed psychotropic medication. The AC/MDSN stated the level I PASARR was not accurate and the facility should have completed another PASARR assessment. The AC/MDSN stated she was responsible in making sure there was a PASARR assessment for new admissions and to review for accuracy. The AC/MDSN stated she did not review Resident 2's level I PASARR assessment and she should have. During an interview on 7/28/25 at 11:40 a.m. with the Director of Nursing (DON), the DON stated the AC/MDSN was responsible in making sure there was a completed PASARR assessment for all new admissions. The DON stated GACH are completing the PASARR assessments and send a copy to the facility prior to resident being discharged . The DON stated her expectation was for the AC/MDSN to review PASARR assessment for accuracy and completed another assessment if PASARR assessment was not accurate. During a review of facility's policy and procedure (P&P) titled, Preadmission SCREENING and RESIDENT REVIEW [PASRR], dated 11/17, the P&P indicated, . each resident admitted to the facility, regardless of payer source, should have a PASRR level I screening completed . Identify residents with mental illness [MI] and/or intellectual disability [ID] . Complete the On-line . Level I screen and submit electronically to Department of Health Care Services [DHCS] . When there is Significant Change in resident's physical or mental condition .</p>		

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Palm Village Retirement Comm.		STREET ADDRESS, CITY, STATE, ZIP CODE 703 W Herbert Ave Reedley, CA 93654	
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 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed twice to complete a level 1 Preadmission Screening and Resident Review (PASARR), (a Federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) screening notifying the state mental health authority or state intellectual disability authority promptly after a significant change for one of three sampled residents (Resident 4). This failure had the potential for Resident 4 to not receive the appropriate services related to her mental disorder. Findings: During a record review of Resident 4's admission Record (AR) (a summary of important information regarding a resident which includes resident identification, past medical history insurance status, care providers, family contact information and other pertinent information), dated 7/25/25, the AR indicated, Resident 4, a [AGE] year-old female was admitted to the facility on [DATE] from another nursing home, and prior to that an acute care hospital, with diagnoses which included: Alzheimer's disease (a condition that affects the brain that makes it hard for people to remember things, think clearly, and do everyday activities), Encounter for palliative care (a type of medical care that helps people who have serious illnesses feel better; it focuses on relieving symptoms like pain, stress, and other problems, rather than trying to cure the illness), Unspecified psychosis (a condition where a person experiences a loss of contact with reality, leading to distorted perceptions and thoughts), Major depressive disorder (persistent sadness, loss of interest in activities and difficulty with relationships impacting a person's thinking and behavior), Other mixed anxiety disorders (a group of conditions characterized by excessive fear, worry, and anxiety that significantly interfere with daily life), . During a record review of Resident 4's Minimum Data Set (MDS) (a federally mandated resident assessment tool), dated 3/25/25, the MDS section C - Cognitive patterns, indicated a Brief Interview for Mental Status (BIMS) (an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) could not be conducted for Resident 4 as Resident is rarely/never understood. During a record review of Resident 4's PASARR Level I Screening Report dated 6/21/23, the PASARR indicated .that a Level II Mental Health Evaluation was not scheduled for the following reason: The individual has no serious mental illness (SMI).the case is now closed. During a concurrent interview and record review on 7/24/25 with the admission Coordinator/MDS Coordinator (AC/MDSN), the AC/MDSN stated that when a resident comes from a hospital or another skilled nursing facility, they use the PASARR that is done at hospital. If the admission comes directly from home, the AC/MDSN completes the PASARR. On every admission the AC/MDSN states that she reviews the diagnosis on the PASARRs for consistency. If inconsistencies are identified the AC/MDSN informs the Director of Nurses (DON) and another PASARR is completed. AC/MDSN stated that any significant change of condition triggers a PASARR level I to be completed. AC/MDSN stated that a change of condition can include a significant medication change, illness, hospitalization, and hospice admission. Record review indicated that Resident 4 was admitted [DATE]. PASARR was completed 6/21/23 at the acute care hospital. The PASARR indicated, The individual has no serious mental illness (SMI). Resident 4's diagnosis once admitted to the facility was Alzheimer's, Unspecified psychosis, Depression, History of falls. AC/MDSN stated that a PASARR level I should have been completed. AC/MDSN stated that when Resident 4 was admitted to Hospice on 2/24/25 a PASARR level I should have been completed. AC/MDSN stated that completing a PASARR is important to determine if the resident's needs can continue to be met at the facility. During a concurrent interview and record review on 7/29/25 at 9:06 a.m. with the Director of Nurses (DON) the DON stated there should have been a PASSAR completed when Resident 4 arrived as the initial PASSAR for [Name of acute care Hospital] stated, The individual has no serious mental illness (SMI), the DON stated that when Resident 4 arrived, resident had multiple behavior issues and a bi-polar diagnosis. DON stated that another PASSAR should have been completed. DON also stated that an additional PASSAR should have been done when Resident 4 was moved to Hospice. DON stated that it is important to complete PASSARs to make sure that residents are getting their needs met, that they are on the appropriate medications and that are in the correct facility. During a record review of the facility's policy and procedure titled, Preadmission Screening and Resident Review (PASRR) dated 11/2017, the document indicated the guidelines for Level I PASSR to be completed, .when there is Significant Change in resident's physical or mental condition. During a record review of the MDS Coordinator's job description dated 2/2016, the job description indicated that purpose of the MDS Coordinator's role included that the MDS Coordinator is to</p>		

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a baseline care plan (a plan that provides direction for individualized care of the resident) within 48 hours of resident's admission for one of four sampled residents (Resident 12) when Resident 12's care plan was not created for the use of antibiotic (medication used to treat infection) from 6/25/25-6/30/25. This failure had the potential for Resident 12 to experience side effects of antibiotic medication like diarrhea, nausea or vomiting and headache and for resident to not receive the therapeutic effects of the medication if staff was not monitoring the effectiveness of antibiotic therapy. Findings:During concurrent observation and interview on 7/22/25 at 10:50 a.m. during the initial tour in Resident 12's room, Resident 12 was sitting up in his wheelchair at bedside watching TV and did not answer questions asked. Resident 12's Responsible Party/Spouse (R/P) was standing outside of the door while nursing staff was providing care to Resident 12. R/P stated Resident 12 had a decline in his activities of daily living (ADL-routine task/activities such as bathing, dressing and toileting a person performs daily to care for themselves), developed respiratory problem and was coughing and was prescribed antibiotic and has now improved. During a review of Resident 12's admission Record [AR-s document containing resident profile information], dated 7/25/25, the AR indicated Resident 12 was admitted to the facility on [DATE] with diagnoses which included dementia (a progressive state of decline in mental abilities), history of falling and hypertension (HTN- high blood pressure). During a review of Resident 12's Order Summary Report [OSR], dated 7/25/25, the OSR indicated, .(brand name)[antibiotic medication used to treat infection]) Oral Tablet 500 MG [milligram-unit of measurement] Give one (1) tablet by mouth one time only for cough for 1 day . Order Date: 6/25/25, Start Date: 6/25/25 . (brand name) Oral tablet 250 MG . for four (4) days . Start Date: 6/6/25 . During a concurrent interview and record review on 7/25/26 at 9:23 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 12's clinical record was reviewed. LVN 2 stated Resident 12 started on antibiotic on 6/25/25 for cough and it was given for five days. LVN 2 stated there was no care plan found for the antibiotic. LVN 2 stated care plan should have been initiated right away to monitor side effects and progress of medication. LVN 2 stated it was the responsibility of the licensed nurses who entered the order to ensure a care plan was initiated . During an interview on 7/29/25 at 11:45 a.m. with the Director of Nursing (DON), the DON stated baseline care plans are the responsibility of all licensed nurses and the expectation was to initiate and complete within 48 hours. The DON stated the licensed nurse who entered the order should have initiated the care plan. The DON stated care plans are important to direct staff on the care of residents and monitor for any side effects of medications and to monitor progress. During a review of facility's document titled, Job Description: Director of Nursing, dated 4/04, the Job Description indicated, . Ensures that required documentations concerning care plans, treatment plans, nurses notes, physician's orders, accident/incident reports, discharges, transfers . are properly charted and transcribed, have required approvals and are entered in the resident's medical records . During a review of facility's policy and procedure (P&P) titled, Policy and Procedure for Baseline Care Plans, undated, the P&P indicated, . The baseline care plan will ensure that the resident's immediate needs are being addressed and will be used to promote the continuity of care . The baseline care plan needs to address resident specific health and safety concerns, the need for supervision, behavioral interventions .</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a comprehensive resident-centered care plan for two of five sample residents (Resident 60 and Resident 1) when:1. Resident 60's care plans did not include the physician prescribed oxygen (O2- a colorless, odorless and tasteless gas essential for life) therapy.This failure had the potential for Resident 60 to experience shortness of breath, respiratory distress, decrease oxygen saturation, confusion, loss of consciousness and respiratory failure (a condition where there is not enough oxygen or too much carbon dioxide in your body).2. Resident 1 did not have a care plan developed for anticoagulant (medication used to prevent blood clots) use, Physical Therapy (PT) and Occupational therapy (OT) treatments.These failures had the potential for side effects of anticoagulant therapy, such as excessive bleeding and blood loss, to go unrecognized by staff, which could result in an emergency medical condition. These failures also had the potential for progress or decline in Resident 1's physical abilities to go unnoticed and for PT/OT to not be adjusted to achieve maximum therapeutic results. Findings:1. During a review of Resident 60'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 7/28/25, the AR indicated, Resident 60, was admitted to the facility on [DATE], was sent out to the hospital and returned to the facility on [DATE]. Resident 60's diagnoses included .congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), hypertensive (high blood pressure) heart disease with heart failure, gastroesophageal reflux disease (GERD- is a digestive disorder where stomach acid frequently flows back into the esophagus, causing heartburn and other symptoms), insomnia (trouble falling asleep or staying asleep), unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 60's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 6/9/25, the MDS section C indicated, Resident 60's Brief Interview for Mental Status (BIMS) assessment score was 6 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 60 had severe cognitive deficit.During a concurrent observation and interview on 7/22/25 at 9:31 a.m. with Resident 60 during the initial tour in Resident 60's Room, Resident 60 was lying in bed with eyes closed and a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing) and was set to 2 LPM (liter per minute- a unit of measurement for the flow rate of oxygen). During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with Director of Staff Development (DSD), Resident 60's care plans and Order Summary Report (OSR) dated 6/2/25 were reviewed. The OSR indicated .oxygen 2L/Min (LPM-liters per minute-unit of measurement) via NC continuous every shift on 6/2/25. The review of Resident 60 care plans indicated there was no O2 care plan for Resident 60. The DSD stated the care plan should have been initiated within 24 hours of the O2 order. The DSD stated there should have been an O2 care plan for Resident 60 since she had orders for O2. The DSD stated the importance of the care plan is to ensure oncoming staff and other staff can plan and know the plan-of- care for Resident 60. The DSD stated it was also important because if any changes needed to be made, then it could have been updated and if new interventions needed to be done, it could have been done. The DSD stated not having a care plan for Resident 60 could have potentially resulted in an error in Resident 60's care.During an interview on 7/25/25 at 3:12 p.m. with admission Coordinator/ Minimum Data Set Nurse (AC/MDSN), the AC/MDSN stated it is the responsibility of the LNs and MDSN to complete the care plan. The AC/MDSN stated when a resident is admitted , the facility has 21 days to complete the resident's care plan. The AC/MDSN stated the care plan is important because it gives an overall picture of the residents' condition so that their plan-of-care can be completed.During a concurrent interview and record review on 7/29/25 at 11:05 a.m. with the Director of Nursing (DON), Resident 60's care plans and Order Summary Report (OSR) dated 6/2/25 were reviewed. The DON validated Resident 60 had an O2 order on 6/2/25. The DON validated there was no O2 care plan for Resident 60. The DON stated the expectation was once there is an O2 order, a care plan should have been completed within 24 hrs. The DON stated a care plan that addressed the O2 needs of Resident 60</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of quality for five of fourteen sampled residents (Resident 60, Resident 87, Resident 32, Resident 2 and Resident 79) when:1. The Licensed nurse (LN) did not accurately assess and document Resident 60's change in skin condition on the weekly assessment.This failure had the potential for Resident 60 to experience worsening skin conditions, declining health status, hospitalization and or death.2.Resident 87 did not receive oxygen (O2- a colorless, odorless and tasteless gas essential for life) therapy as ordered by the physician on 7/1/25.This failure placed Resident 87 at risk for experiencing shortness of breath (SOB) and respiratory distress (difficulty breathing).3. Resident 32's Oxygen therapy (a colorless, odorless, tasteless gas essential to living organisms) was not administered per the physician order. This failure resulted in Resident 32 not receiving her oxygen therapy as ordered which had the potential to result in nasal dryness, shortness of breath, oxygen toxicity (lung damage that happens from breathing in too much extra Oxygen therapy), and serious medical condition.4. Resident 2's order for Trazodone hydrochloride from [name of hospice company] dated 7/3/25 was filed in Resident 2's chart and was not carried out. This failure had the potential for Resident 2's health to decline due to not receiving the medication ordered.5. Resident 79's oxygen flow rate was set to three liters (L- units of measurement) not the order of 2L.This failure has the potential to result in respiratory distress (difficulty breathing) for Resident 79.Findings:</p> <p>1. During a review of Resident 60's &ldquo;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)&rdquo;, dated 7/28/25, the &ldquo;AR&rdquo; indicated, Resident 60, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included &ldquo;&hellip; fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, unspecified dementia (a progressive state of decline in mental abilities)&hellip;&rdquo;</p> <p>During a review of Resident 60's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 6/9/25, the &ldquo;MDS&rdquo; section C indicated, Resident 60's Brief Interview for Mental Status (BIMS) assessment score was 6 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 60 had severe cognitive deficit.</p> <p>During a concurrent observation and interview on 7/22/25 at 9:31 a.m. with Resident 60 during the initial tour in Resident 60&rsquo;s Room, Resident 60 was lying in bed with eyes closed and a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing) and was set to 2 LPM (liter per minute- a unit of measurement for the flow rate of oxygen).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/23/25 at 10:55 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 60's records titled "Skin check" dated 7/22/25 at 3:36 p.m. and "Weekly Assessment 2" (WA2) dated 7/22/25 at 11:22 p.m. were reviewed. The "Skin check" indicated Resident had a deep tissue Injury (DTI- damage to underlying soft tissue, often muscle, caused by prolonged pressure or shear forces, which can lead to cell death and tissue damage) to coccyx area (small triangular bone at the base of the spinal column in humans), it has purple discoloration to area, 3x3cm, skin intact. The "WA2" indicated there was no documentation of Resident 60's DTI. LVN 3 confirmed that Resident 60's skin assessment was not documented in the weekly assessment. LVN 3 stated Certified Nursing Assistant (CNA) examine residents' skin during bathing and report findings, while LNs assess residents' skin during weekly assessment. LVN 3 stated the LN should have documented the DTI in the weekly assessment. LVN 3 stated proper skin assessment ensures skin integrity is maintained. LVN 3 stated documenting skin assessments was important as it formed part of the care intervention.</p> <p>During a concurrent interview and record review on 7/23/25 at 3:48 p.m. with Licensed Vocational Nurse (LVN) 6 Resident 60's Resident 60's records titled "Skin check" dated 7/22/25 at 3:36 p.m. and (WA2) dated 7/22/25 at 11:22 p.m. were reviewed. LVN 6 stated she did not conduct a comprehensive body assessment. LVN 6 stated that conducting a complete body assessment was important for identifying any new skin conditions and changes that needed to be reported. LVN 6 stated she had been unaware Resident 60 had a DTI. LVN 6 stated if she had completed the assessment, she would not have missed the DTI. LVN 6 stated the potential outcome for not assessing Resident 60 was that the wound could have gone undetected with no corrective action taken, which could have led to additional skin breakdown, wound deterioration and decline in Resident 60's overall health.</p> <p>During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with Director of Staff Development (DSD), Resident 60's "Skin check" and "WA2" were reviewed. The DSD stated weekly assessments included head to toe assessments, weekly checkups, medication changes, and skin checks. The DSD stated the LN should have completed a skin assessment. The DSD stated the importance of completing a skin assessment was to find any new skin changes and provide appropriate treatment or care. The DSD stated not conducting assessments could have resulted in potential outcomes where the wound could have gotten bigger, remained undetected and gone untreated.</p> <p>During an interview on 7/29/25 at 11:05 a.m. with the Director of Nursing (DON), the DON stated the weekly assessments help LNs track what occurred during the week including medication changes, skin changes, falls and any condition changes in residents. The DON stated when weekly assessments are conducted, the expectation is that LNs complete and accurately input their assessments. The DON stated the weekly assessment ensures the facility can plan appropriate treatment and address any ongoing resident conditions.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Prevention of Pressure Injuries" dated 2001, the "P&P" indicated, 3. Inspect skin on a daily basis; Monitoring 1. Evaluate, report and document potential changes in the skin;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, Pressure Injury Risk Assessment revised 9/2024, the "P&P" indicated, 4. Conduct a comprehensive skin assessment; b. once inspection of skin is completed document the findings on a facility approved skin assessment tool; Documentation. The following information should be recorded in the resident's medical record; 5. The condition of the resident's skin (i.e., the size and location of any red or tender areas) ; and;</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (LVN), dated 9/2017, the document indicated .7. receives and follows up on resident report from nurse on previous shift; 6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care; and;</p> <p>During a review of the facility's document titled, Job Description, Director of Nursing, dated 4/2004, the document indicated .7. ensures that required documentation concerning care plans, treatment plans, nurses' notes, ; accident/incident reports; etc. are properly charted ; and are entered in the resident's medical record in accordance with established procedures; and;</p> <p>During a review of Nursing World.org Professional Reference titled, "The American Nurses Association- Nursing: Scope and Standards of Practice, Third Edition", dated July 2015, (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, "The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making; Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation; and;</p> <p>2. During a review of Resident 87's "AR" dated 7/28/25, the "AR" indicated, Resident 87, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included ; dependence on supplemental oxygen, congestive heart failure, acute respiratory failure with hypoxia, dyspnea, altered mental status; and;</p> <p>During a review of Resident 87's MDS assessment, dated 7/3/25, the "MDS" section C indicated, Resident 87's "BIMS" assessment score was 3 out of 15. The BIMS scores indicated Resident 87 had severe cognitive deficit.</p> <p>During a review of Resident 87's MDS assessment, dated 7/3/25, the "MDS" section O indicated, Resident 87's "Special Treatment, Procedures, and Programs" indicated Resident 87 was on continuous oxygen therapy on admission and while as a resident.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During concurrent observation and interview on 7/22/25 at 10:28 a.m. at Resident 87's room, the doorway had a posted Oxygen in Use/No Smoking sign. CNA 4 and CNA 5 were seen transferring Resident 87 from her highchair to her bed. Resident 87's highchair had a portable oxygen cylinder strapped to the stand behind the highchair. There was no nasal cannula (NC- a tube that directs oxygen into the nose) or bag to store the NC seen attached to O2 cylinder behind Resident 87's highchair. There was no O2 concentrator by Resident 87's bedside. Resident 87 was lying in bed and did not have any O2 tubing attached to her nose. CNA 4 stated Resident 87 was not on O2 therapy. Resident 87 stated "I don't use O2".</p> <p>During an observation on 07/23/2025 at 8:31 a.m. in Resident 87's room, Resident 87 was sitting in her highchair, dressed in own clothes, there was no O2 concentrator by Resident 87's bedside. There was an O2 cylinder behind the highchair. There was no NC seen attached to the O2 cylinder or connected to Resident 87's nose.</p> <p>During a concurrent interview and record review on 7/24/25 at 10:55 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 87's Order Summary Report (OSR) dated 7/1/25 at 1:49 p.m. was reviewed. The OSR indicated "Oxygen at 1 L/Min (LPM-liters per minute-unit of measurement) via NC continuous every shift." LVN 3 stated Resident 87 was not on O2 at that time but was on O2 when she was first admitted to the facility. LVN 3 stated Resident 87 had provider's order for O2 on 7/1/25. LVN 3 stated there was no O2 concentrator in Resident 87's room.</p> <p>During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with the Director of Staff Development (DSD), Resident 87's "OSR" dated 7/1/25 at 1:49 p.m. was reviewed. The DSD stated an O2 order will require the use of O2, an O2 cylinder on the resident's wheelchair, a NC and a bag to store the NC. The DSD validated the provider's order was O2 at 1LPM via NC continuous every shift. The DSD stated Resident 87 should have had a concentrator. The DSD stated the provider's order for O2 therapy was not followed.</p> <p>During a concurrent interview and record review on 7/29/25 at 11:05 a.m. with Director of Nursing (DON), a photo of Resident 87's O2 cylinder with no NC and Resident 87's "OSR" dated 7/1/25 at 1:49 p.m. were reviewed. The DON stated LNs were expected to follow the provider's orders. The DON stated the LNs had not followed the provider's O2 orders for Resident 87. The DON stated the importance of following the provider's orders was to ensure effective treatment and residents' safety. The DON stated the expectation from LNs was that the NC tubing should have been kept in a storage bag attached to the O2 cylinder. The DON stated the NC tubing attached to the O2 cylinder was for immediate use in case Resident 87 had experienced SOB. The DON stated Resident 87 should have had an O2 concentrator in the room. The DON stated it was important that an O2 concentrator was available in the room in case Resident 87 had experienced SOB and to ensure Resident 87 did not go into respiratory distress.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Administering Medications," dated 4/2019, the P&P indicated, "Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. 2. The Director of nursing services supervises and directs all personnel who administer medications and /or have related functions;4;medications are administered in accordance with prescriber orders;"</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, "Oxygen Administration," dated 10/2010, the P&P indicated, "Purpose is to provide guidelines for safe oxygen administration. verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration; Equipment and Supplies. The following equipment and supplies will be necessary when performing this procedure. 1. Portable oxygen cylinder (strapped to the stand); 2. Nasal cannula, nasal catheter, mask (as ordered)";</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (LVN), dated 9/2017, the document indicated . Primary Job Duties 3. receives doctors' orders; 4. Reviews medication orders; 8. Administers prescribed medication and treatments as ordered by the physician. Charts same and notes all effects; 6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care";</p> <p>During a review of the facility's document titled, "Job Description, Staff Nurse/Charge Nurse (RN)," dated 8/2017, the document indicated .Primary Job Duties: 3. Administers medications, receives doctors' orders, 8. Administers prescribed medication and treatments as ordered by the physician. Charts same and notes all effects; 6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care";</p> <p>During a review of the facility's document titled, Job Description, Director of Nursing, dated 4/2004, the document indicated .7. ensures that required documentation concerning care plans, treatment plans, nurses' notes, physician's orders; etc. are properly charted and are entered in the resident's medical record in accordance with established procedures; 9. Makes periodic all shifts to assure that prescribed treatments and services are properly administered";</p> <p>During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse .</p> <p>3. During a review of Resident 32'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 7/24/25, the "AR" indicated Resident 32 was admitted to the facility on [DATE] with diagnoses of congestive heart failure (chronic condition where the heart muscle cannot pump enough blood to meet the body's need), shortness of breath, chronic respiratory failure with hypoxia (condition where the lungs cannot adequately oxygenate the blood resulting in low blood oxygen levels) and dyspnea (feeling of shortness of breath or difficulty breathing).</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Resident 32's "Minimum Data Set" (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/15/25, the "MDS" indicated Resident 32 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 5 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 32 was severely cognitively impaired.</p> <p>During an observation on 7/22/25 at 9:59 a.m. in Resident 32's room, Resident 32 was observed lying in bed, eyes closed with her nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) in her nose. Resident 32's nasal cannula was observed connected to the oxygen concentrator (medical device that helps residents breathe). The oxygen concentrator was observed on the left side of the bed turned on at 3 LPM (liter per minute- a unit of measurement for the flow rate of oxygen).</p> <p>During a concurrent interview and record review on 7/25/25 at 1:21 p.m. with Licensed Vocational Nurse (LVN) 1, a photo of Resident 32's oxygen concentrator, dated 7/22/25 and "Order Summary Report," dated 7/25/25 was reviewed. LVN 1 stated Resident 32 had an active order for oxygen 2 LPM via nasal cannula continuous. LVN 1 stated oxygen was a medication and was to be administered per the provider order. LVN 1 stated LVNs were responsible to ensure oxygen was administered per the provider order. LVN 1 stated Resident 32 received the incorrect administration of oxygen on 7/22/25 when the oxygen concentrator was set on 3 LPM. LVN 1 stated Resident 32 had diagnoses of acute respiratory failure and congestive heart failure, which placed her at risk for increased work of breathing and oxygen toxicity with the administration of excessive oxygen therapy.</p> <p>During an interview on 7/25/25 at 1:32 p.m. with LVN 5, LVN 5 stated he was the charge nurse of the unit. LVN 5 stated oxygen was a medication and LVN's were responsible to administer oxygen per provider orders. LVN 5 stated it was important to administer oxygen as ordered to ensure the full benefit of oxygen therapy was received and monitored accurately for effectiveness.</p> <p>During a concurrent interview and record review on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), a photo of Resident 32's oxygen concentrator, dated 7/22/25 and "Order Summary Report," dated 7/29/25 was reviewed. The DON stated Resident 32 had an active order for oxygen therapy at 2 LPM via nasal cannula continuously. The DON stated Resident 32 received 3 LPM oxygen via nasal cannula on 7/22/25 and provider orders were not followed. The DON stated oxygen was a medication and she expected all licensed staff to administer medication per the provider order. The DON stated it was important to administer oxygen as ordered to ensure Resident 32's diagnoses were treated and maintained. The DON stated Resident 32 was at risk for oxygen toxicity and serious medical condition which could be detrimental to her care when the incorrect amount of oxygen was administered. The DON stated professional standards of practice, facility policy and procedure, and expectations were not followed when Resident 32 received the incorrect administration of 3 LPM oxygen therapy on 7/22/25.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Oxygen Administration," dated 10/2010, the P&P indicated, "verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration";</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's P&P titled, "Administering Medications," dated 4/2019, the P&P indicated, "medications are administered in accordance with prescriber orders";</p> <p>During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, "Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse .</p> <p>4. During a review of Resident 2's admission Record [AR- a document containing resident profile information), dated 7/25/25, the AR indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses which included heart failure, palliative care (care focused on improving the quality of life for individuals and families facing serious, life-threatening illness by relieving suffering and providing support) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).</p> <p>During a concurrent interview and record review on 7/25/25 at 3:05 p.m. with Medical Records (MR), the MR reviewed Resident 2's clinical records titled Physicians Order Sheet dated 7/3/25 the medication order from hospice was reviewed. MR stated, It does not look like it was carried out. The MR stated the licensed nurse receiving the order was supposed to have reached out to the primary doctor to clarify the order and entered the order in Resident 2's order summary sheet but it was not done. The MR stated the practice was for licensed nurses to date and sign the order once it was carried out and then file in resident chart. The MR stated it was the responsibility of licensed nurses to ensure all orders are carried out.</p> <p>During a concurrent interview and record review on 7/25/25 at 3:30 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 2's clinical document in the chart titled Physician's Order Sheet dated 7/3/25. LVN 2 stated the medication order from hospice was filed in Resident 2's chart but was not carried out. LVN 2 stated the process when receiving an order from hospice was to notify the primary doctor of resident, call family then enter the order if both the primary doctor and family agreed. LVN 2 stated the primary doctor and family should have been notified and entered the medication order in Resident 2's clinical record in order to administer medication to Resident 2. LVN 2 stated it was the responsibility of all licensed nurses to ensure all medication orders are carried out. LVN 2 stated Resident 2's health status could be affected because the medication was not carried out and administered.</p> <p>During an interview on 7/29/25 at 12:05 p.m. with the Director of Nursing (DON), the DON stated she did not know who pulled out the document and filed in Resident 2's chart without reviewing and carrying out the order. The DON stated she talked to LVN 2 who stated she did not remember calling hospice and requesting to increase Resident 2's medication. The DON stated, My expectation was for all licensed nurses to ensure all orders are carried out. The DON stated licensed nurses should have reached out to the primary doctor, verified the order then notified family and carried out the order.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of Facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 7/22, the P&P indicated, . When determining whether to initiate, modify, or discontinue medication therapy, the Interdisciplinary Team (IDT- group of healthcare professionals from different fields who collaborate to provide comprehensive care for patients) conducts an evaluation of the resident. The evaluation will attempt to clarify whether: a. other causes for symptoms (including symptoms that mimic a psychotic disorder) have been ruled out; . d. the actual or intended benefit of the medication is understood by the resident/representative . The staff and physician will review with the resident/representative the risk related to not taking the medication as well as appropriate alternatives.</p> <p>During a professional reference review retrieved from https://www.ncbi.nlm.nih.gov/books/NBK43696/, undated the professional indicated, .Whether they are printed on paper or available for electronic access, development and implementation of well designed , preprinted physician orders requires engineering, education, and enforcement . Orders are the initial means that enable physicians to communicate with a variety of interdisciplinary hospital caregivers, and they represent the starting point for action and care. In the healthcare environment, nothing goes forward without calling on the assistance of and providing direction through physician orders .</p> <p>5. During observation on 7/22/25 at 9:25 a.m. with Resident 79 in Resident 79's room, observed Resident 79 in bed, the Nasal Cannula (NC the tube that delivers oxygen through the nose to people who have low oxygen levels) on and set to 3L.</p> <p>During a review of Resident 79's admission Record (AR) dated 7/25/25, the AR indicated, Resident 79 was initially admitted to the facility on [DATE] with diagnoses of Morbid Obesity (a severe form of obesity characterized by an extremely high body mass index [BMI]), hypertension (HTN- high blood pressure) and gastroesophageal reflux disease ([GERD] is a digestive disorder where stomach acid frequently flows back into the esophagus, causing heartburn and other symptoms).</p> <p>During a review of Resident 79's Order Summary Report (OSR) dated 7/17/25, the OSR indicated, &hellip;Oxygen- At 2 liters (unit of measurement) per/minute via Nasal cannula prn (as needed) shortness of breath .</p> <p>During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/8/25, the MDS section C indicated Resident 79 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 79 was cognitively intact.</p> <p>During a concurrent interview and record review on 7/24/25 at 1:44 p.m. with Licensed Vocational Nurse (LVN) 1, a photo of Resident 79's oxygen concentrator, dated 7/22/25 and Order Summary Report, dated 7/16/25 was reviewed. LVN 1 stated Resident 79 had an active order for oxygen 2 LPM via nasal cannula continuous. LVN 1 stated oxygen should be administered per the provider order. LVN 1 stated LVNs were responsible to ensure oxygen was administered per the provider order. LVN 1 stated Resident 79 received the incorrect administration of oxygen on 7/22/25 when the oxygen concentrator was set on 3 LP.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/25/25 at 2:30 p.m. with LVN 2, LVN 2 stated oxygen was a medication and LVN's were responsible to administer oxygen per provider orders. LVN 2 stated it was important to follow the order directly as written. LVN 2 stated staff and residents were educated on oxygen use and not to increase or decrease the oxygen flow rate without provider orders.</p> <p>During a concurrent interview and record review on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), a photo of Resident 79's oxygen concentrator, dated 7/22/25 and "Order Summary Report," dated 7/16/25 was reviewed. The DON stated Resident 79 had an active order for oxygen therapy at 2 LPM via nasal cannula continuously. The DON stated Resident 79 received 3 LPM oxygen via nasal cannula on 7/22/25 and provider orders were not followed. The DON stated it was important to administer oxygen as ordered because oxygen is a medication. The DON stated professional standards of practice, facility policy and procedure, and expectations were not followed when Resident 79 received the incorrect administration of 3 LPM oxygen therapy on 7/22/25.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Oxygen Administration," dated 10/2010, the P&P indicated, "verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration";</p> <p>During a review of the facility's P&P titled, "Administering Medications," dated 4/2019, the P&P indicated, "medications are administered in accordance with prescriber orders";</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of eleven sampled residents' (Resident 12 and Resident 79) drug regimen was free from unnecessary drugs when: Resident 79 received acetaminophen-codeine (opioid and nonopioid combination prescription medication used to treat pain) tablet prescribed for severe pain, despite reporting moderate pain on 7/19/25, 7/20/25, 7/21/25, 7/22/25, 7/23/25, and 7/24/25. This failure resulted in over-medication and inadequate pain management practices of Resident 79 which had the potential to result in adverse consequences and complications which could lead to serious medical condition. 2. Licensed Nurses did not follow physician ordered acetaminophen medication when Resident 12 was administered acetaminophen for complaints of pain, the acetaminophen was ordered for temperatures above 101 degrees Fahrenheit. This failure had the potential for Resident 12 to not receive adequate pain relief .</p> <p>Findings:</p> <p>1. During a review of Resident 79'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 7/24/25, the AR indicated Resident 79 was admitted to the facility on [DATE] with diagnoses of muscle weakness, intervertebral disc degeneration in the lumbar region with discogenic back pain (breakdown and wear of the spinal discs in the lower back, causing pain), lumbar region radiculopathy (condition where nerve root in the lower back is compressed, causing pain), osseous and spondylosis of lumbar region (condition where bones in the spine are misaligned, causing pain).</p> <p>During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/8/25, the MDS indicated Resident 79 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 79 was cognitively intact.</p> <p>During an observation on 7/24/25 at 11:33 a.m. in Resident 79's room, Licensed Vocational Nurse (LVN) 1 was observed during medication pass. LVN 1 asked Resident 79 to rate her pain on a scale of 0-10, Resident 79 stated her pain was a 5 out of 10. LVN 1 administered, acetaminophen-codeine (opioid and nonopioid combination prescription medication used to treat pain) oral tablet 300-30 MG (milligram- a unit of measurement to determine medication dosage) for severe pain;</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 79's "Order Summary Report," dated 7/24/25, and Resident 79's "Medication Administration Record (MAR)," dated 7/24/25, the "Order Summary Report" indicated, Resident 79 had an order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain .start date 7/18/25&hellip;,[discontinued] date 7/23/25&hellip;"; The "Order Summary Report" indicated, Resident 79 had a renewed active order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain .start date 7/23/25&hellip;"; Resident 79's "MAR" indicated, "1-10 pain scale&hellip;0- no [signs and symptoms] of pain&hellip;1-2 least pain&hellip;3-4 mild pain&hellip;5-6 moderate pain&hellip;. 7-8 severe&hellip;9-10 excruciating&hellip;"; Resident 79's "MAR" indicated, LVN 1 recorded a pain assessment of 5 out of 10 prior to the administration of "acetaminophen-codeine 300-30 MG&hellip;for severe pain&hellip;"; on 7/24/25 at 11:33 a.m. Resident 79's "MAR" indicated, acetaminophen-codeine oral tablet 300-30 MG was administered 21 times between 7/19/25- 7/24/25 with documented pain ratings between 0-6 out of 10, which indicated no pain to moderate pain.</p> <p>During a concurrent interview and record review on 7/24/25 at 2:03 p.m. with LVN 1, Resident 79's "MAR," dated 7/24/25 was reviewed. LVN 1 stated she administered acetaminophen-codeine oral tablet 300-30 MG to Resident 79 for a reported pain of 5 out of 10 on the pain scale, which indicated moderate pain. LVN 1 stated Resident 79's orders indicated acetaminophen-codeine oral tablet 300-30 MG was to be administered for severe pain. LVN 1 stated the incorrect pain medication was administered to treat Resident 79's moderate pain. LVN 1 stated Resident 79's order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain&hellip;" should only be administered for a pain rating of 7-8 out of 10 on the pain scale, which indicated severe pain. LVN 1 stated Resident 79's order for, "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain&hellip;" should not have been administered for a pain rating of 5 out of 10 on the pain scale. LVN 1 stated, per Resident 79's "MAR," the order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain&hellip;" was incorrectly administered 21 times between 7/19/25 and 7/24/25 when the medication was administered for pain levels of 0-6 out of 10 on the pain scale. LVN 1 stated it was important to determine pain ratings on the pain scale prior to the administration of pain medication to ensure residents' pain was managed appropriately. LVN 1 stated Resident 79 was at risk of being overmedicated which could lead to drowsiness and negative outcomes. LVN 1 stated it was important to administer the lowest dose possible of pain medication to manage symptoms to prevent the development of tolerance to pain medication. LVN 1 stated it was important to adhere to medication administration instructions to ensure the most appropriate mediation was administered.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 7/25/25 at 2:08 p.m. with the Pharmacist Consultant (PC), the PC stated licensed nursing staff were expected to review administration instructions before administering medications. The PC stated she was responsible for reviewing drug medication regimens once a month to ensure medication administration instructions were appropriate and medications were being administered appropriately per the administration instructions. The PC stated Resident 79's order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain" was not appropriate to administer based on a pain scale rating of 0-6 out of 10. The PC stated a pain rating of 0-6 out of 10 was considered mild to moderate pain. The PC stated Resident 79's order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain" needed an associated pain scale rating of 0-10 within the administration instructions to ensure the most appropriate medication was administered for Resident 79's pain rating.</p> <p>During a concurrent interview and record review on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), Resident 79's "MAR" dated 7/29/25 was reviewed. The DON stated Resident 79 had previous and current orders for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain" which was administered 21 times between 7/19/25 and 7/24/25 for pain ratings of 0-6 out of 10. The DON stated a pain rating of 0-6 out of 10 was considered mild to moderate pain and not severe pain. The DON stated Resident 79's order for "acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain" had not been administered appropriately per administration instructions. The DON stated Resident 79 was at risk for not having her pain managed effectively. The DON stated it was important to administer the lowest dose possible of pain medication to treat pain to prevent overmedication.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Administering Pain Medications" dated 2001, the P&P indicated, "The purpose of this procedure is to provide guidelines assessing the resident's level of pain prior to administering analgesic pain medication; the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice; any resident who uses opioids for long-term management of chronic pain is at risk for opioid overdose; conduct a pain assessment as indicated; administer pain medications";</p> <p>During a review of the facility's P&P titled, "Pain Protocol and Management" 4/2025, the P&P indicated, "the licensed nurse will identify individuals who have pain or who are at risk of having pain; the nurses will use a numerical and PAINAID scale that is appropriate to the residents cognitive level";</p> <p>2. During a concurrent observation and interview on 7/22/25 at 10:50 a.m. outside of Resident 12's room, Resident 12 was up in his wheelchair inside the room and was being helped by nursing staff. Resident 12's Responsible Party (R/P) was standing outside of the room. The R/P stated Resident 12 had a fall a few weeks ago but did not sustain major injury. The R/P stated she was not sure if Resident 12 complained of pain and what medication was available for pain.</p> <p>During a review of Resident 12's eMAR (Electronic Medical Administration Record) dated 6/1/25-6/30/25, the eMAR indicated, "(Tylenol brand name) Oral Tablet; Give 2 tablets by mouth; for temp. over 101 F"; on 6/19/25.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555513	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/29/2025
NAME OF PROVIDER OR SUPPLIER Palm Village Retirement Comm.		STREET ADDRESS, CITY, STATE, ZIP CODE 703 W Herbert Ave Reedley, CA 93654	
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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 12's eMAR dated 7/1/25-7/31/25, the eMAR indicated &ldquo;(Acetaminophen brand name) Oral Tablet &hellip; Give 2 tablets by mouth &hellip; for temp. over 101F&hellip;&rdquo; on 7/23/25.</p> <p>During a concurrent interview and record review on 7/24/25 at 1:55 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated Resident 12 was alert with confusion and responded to verbal stimuli. Resident 12's clinical record was reviewed and LVN 2 stated Resident 12's Acetaminophen order was PRN (as needed) and had a direction to give for temperature over 101 degrees Fahrenheit. LVN 2 stated on 7/23/25, Resident 12 complained of pain to his right lower quadrant (RLQ- region below the belly button, extending from midline to the right, and down to the groin area) and was administered acetaminophen medication. LVN 2 stated on 6/19/25 Resident 12 complained of headache and acetaminophen medication was administered. LVN 2 stated Resident 12 should not have been administered acetaminophen because the medication order was not followed</p> <p>During a phone interview on 7/29/25 at 10:55 a.m. with Pharmacy Consultant (PC), the PC stated acetaminophen medication should not have been administered to Resident 12 when he complained of pain. The PC stated the physician order was not followed when Resident 12 was administered acetaminophen for complaint of pain. The PC stated the acetaminophen was only ordered for temperatures above 101 degrees Fahrenheit and should not have been administered for pain.</p> <p>During an interview on 7/29/25 at 12:05 p.m. with the Director of Nursing (DON), the DON stated Resident 12's acetaminophen order was not followed when he was administered the medication for complaint of pain. The DON stated the licensed nurses did not follow the physician order direction for acetaminophen and they should have. The DON stated licensed nurses should have called the medical doctor and got an order for pain medication when Resident 12 complained of pain. The DON stated her expectation was for staff to always follow physician order and double check medication direction.</p> <p>During a review of facility document titled, Pain Protocol and Management, dated 4/25, the document indicated, . The nursing staff will assess each resident for pain upon admission/readmission to the facility and at the quarterly review . The nursing staff will assess residents for pain every shift and document . Nursing will review pain medication regimen with quarterly assessment/PRN (as needed) .</p> <p>During a review of facility policy and procedure (P&P) titled, Administering Medication, dated 4/19, the P&P indicated, .Only persons licensed or permitted by this state to prepare, administer and document the administration of medication . Medications as administered in accordance with prescriber orders . The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage .</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>(continued on next page)</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was 12 percent. There were 25 opportunities for errors and three medication errors occurred for three of thirteen sampled residents (Resident 26, Resident 65 and Resident 79) when:1. Resident 26 was administered a chewable aspirin tablet with oral medications and swallowed whole.2. Resident 65 was administered a chewable aspirin tablet with oral medications and swallowed whole.3. Resident 79 was administered pain medication prescribed for severe pain, despite reporting moderate pain.These failures resulted in the incorrect administration of medication which could lead to a reduction of medication effectiveness, under medication or overmedication and negative outcomes.Findings:1. During a medication pass observation on 7/23/25 at 8:54 a.m., Resident 26 was observed in the hallway seated in her wheelchair. Resident 26 was observed to be wheeled into her room by Licensed Vocational Nurse (LVN) 3. LVN 3 was observed preparing and administering aspirin 81 MG (milligrams- a unit of measurement to determine medication dosage) with additional medication into a cup. Resident 26 was observed swallowing all her medication whole from the cup.During a record review of Resident 26's Order Summary Report, dated 7/23/25, the Order Summary Report indicated, Resident 26 had an active order for .aspirin 81 MG oral tablet chewable.give 1 tablet by mouth one time a day for CVA (cerebrovascular accident-condition where blood flow to the brain is interrupted and leads to a stroke) [prophylaxis-preventative treatment].order start date 7/15/23. 2. During a medication pass observation on 7/23/25 at 8:04 a.m. Resident 65 was observed seated in his room. LVN 3 was observed preparing and administering aspirin 81 MG with additional medication into a cup. Resident 26 was observed swallowing all his medication whole from the cup.During a record review of Resident 65's Order Summary Report, dated 7/23/25 , the Order Summary Report, indicated, Resident 65 had an active order for .aspirin 81 MG oral tablet chewable. give 1 tablet by mouth one time a day related to atherosclerotic heart disease of native coronary artery without angina pectoris [plaque buildup in the heart's major arteries without chest pain].order start date 6/25/24. During a concurrent interview and record review on 7/23/25 at 2:08 p.m. with LVN 3, Resident 26's and Resident 65's Order Summary Report, dated 7/23/25 was reviewed. LVN 3 stated Resident 26 and Resident 65 had an active order for .aspirin 81 MG oral tablet chewable. LVN 3 stated Resident 26's and Resident 65's aspirin should have been separated from other medication to ensure Resident 26 and Resident 65 chewed the aspirin, per administration instructions. LVN 3 stated it was important to administer medications as per the medication instructions to ensure each Resident received the full effect of the medication.3. During a medication pass observation on 7/24/25 at 11:33 a.m. Resident 79 was observed lying in bed. LVN 1 was observed asking Resident 79 to rate her pain on a scale of 0-10, Resident 79 stated her pain was a 5 out of 10. LVN 1 administered acetaminophen-codeine (opioid and nonopioid combination prescription medication used to treat pain) oral tablet 300-30 MG. Resident 79 was observed swallowing the medication. During a record review of Resident 79's Order Summary Report, and Medication Administration Record (MAR), dated 7/24/25 the Order Summary Report indicated, Resident 79 had an active order for .acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain .start date 7/23/25. Resident 79's MAR indicated, .1-10 pain scale.0- no [signs and symptoms] of pain.1-2 least pain.3-4 mild pain.5-6 moderate pain. 7-8 severe.9-10 excruciating. Resident 79's MAR indicated, LVN 1 recorded a pain assessment of 5 out of 10 prior to the administration of .acetaminophen-codeine 300-30 MG.for severe pain. on 7/24/25 at 11:33 a.m.During a concurrent interview and record review on 7/24/25 at 2:03 p.m. with LVN 1, Resident 79's MAR, dated 7/24/25 was reviewed. LVN 1 stated she administered acetaminophen-codeine oral tablet 300-30 MG to Resident 79 for a reported pain of 5 out of 10 on the pain scale, which indicated moderate pain. LVN 1 stated Resident 79's orders indicated acetaminophen-codeine oral tablet 300-30 MG was to be administered for severe pain. LVN 1 stated the incorrect pain medication was administered to treat Resident 79's moderate pain. LVN 1 stated Resident 79's order for .acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain. should only be administered for a pain rating of 7-8 out of 10 on the pain scale, which indicated severe pain. LVN 1 stated Resident 79's order for , .acetaminophen-codeine oral tablet 300-30 MG (acetaminophen with codeine) give 1 tablet by mouth every 6 hours for severe pain. should not have been administered for a pain rating of 5 out of 10 on the pain scale. LVN 1 stated it was important to determine pain ratings on the pain scale prior to the administration of pain</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>(continued on next page)</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review, the facility failed to properly store medications in two of three medication carts when: 1. Medication cart, referred to as, 900-WB, contained three expired prescription medications for two residents (Resident 59 and Resident 90). 2. Medication cart, referred to as, 300-600, contained one expired prescription medication for one resident (Resident 11) and one expired over-the-counter medication. This failure had the potential to decrease medication potency that could compromise the therapeutic effectiveness of stored medications. Findings: 1. During a concurrent observation and interview on 7/23/25 at 2:08 p.m. with Licensed Vocational Nurse (LVN) 3, at medication cart 900-WB, Resident 59's travoprost 0.004% eye drops (prescription eye drop medication that helps lower pressure in the eye) were observed with an expiration date of 7/18/25. Resident 90's lorazepam (prescription oral medication used to treat anxiety) 0.5 MG (milligram- unit of measurement to determine strength of medication) tablets were observed with an expiration date of 7/23/25 and morphine sulfate (prescription oral medication used to treat pain) 15 MG tablets were observed with an expiration date of 3/29/25. LVN 3 stated Resident 59's and Resident 90's medications were expired and were expected to have been removed from the medication cart on or before the date of expiration. LVN 3 stated medications were considered expired on the date of expiration. LVN 3 stated it was important to remove expired medication from the medication cart to prevent the accidental administration of expired medication to residents. LVN 3 stated there was a potential risk for medication error if expired medications were administered to Resident 59 or Resident 90. 2. During a concurrent observation and interview on 7/24/25 at 3:27 p.m. with LVN 4, at medication cart 300-600, Resident 11's acetaminophen 650 MG suppository was observed with an expiration date of 8/30/24. The over-the-counter medication, glucosamine hydrochloride and chondroitin sulfate 500-400 MG dietary supplemental (medication used to support joint health), was observed with an expiration date of 5/2025. LVN 4 stated Resident 11's acetaminophen 650 MG suppository and the over-the-counter glucosamine hydrochloride and chondroitin sulfate 500-400 MG dietary supplemental medication was expired. LVN 4 stated the medication cart should have been removed from the medication cart before or on the expiration dates. LVN 4 stated licensed nursing staff were responsible to check medication carts each shift for expired medications and before administration of medication. LVN 4 stated the Director of Nursing (DON) completed periodic audits of medication carts to ensure expired medications were removed from medication carts. LVN 4 stated Resident 11 and any resident who received the over-the-counter medication, glucosamine hydrochloride and chondroitin sulfate 500-400 MG dietary supplemental were at risk of adverse reactions if they were administered expired medications. During an interview on 7/25/25 at 2:08 p.m. with the Pharmacist Consultant (PC), the PC stated licensed nursing staff completed daily checks of medication carts and removed expired and discontinued medications. The PC stated she completed monthly audits of medication carts to ensure expired and discontinued medications were removed from medication carts. The PC stated the DON completed periodic audits of the medication carts to ensure expired and discontinued medications were removed from medication carts. The PC stated all expired and discontinued medications were expected to be removed from the medication carts, per facility policy and procedure, to ensure expired medications were not administered to residents. The PC stated the strength and potency of medication could not be guaranteed in expired medication. The PC stated if expired medications were left in medication carts, residents were at risk of receiving expired medications which could lead to improper dosing, medication errors, and negative outcomes. During an interview on 7/29/25 at 9:10 a.m. with the Director of Nursing (DON), the DON stated she expected all expired medication to be removed from medication carts on or before the date of expiration, per standards of practice and policy and procedure. The DON stated licensed nurses were responsible to check medication carts each shift and remove expired and discontinued medications. The DON stated the PC was responsible to check medication carts each month and remove expired and discontinued medications. The DON stated she was responsible to perform periodic audits of medication carts to ensure expired and discontinued medications were removed from medication carts. The DON stated it was the responsibility of the facility to maintain a safe medication cart. The DON stated expired medications were not to be left in medication carts as it increased the risk of administering an expired medication to residents, which could cause adverse consequences. The DON stated the potency of medication could not be guaranteed in an expired medication and was unsafe to administer to residents. During a review of the facility's policy and procedure (P&P) titled Administering Medications, dated 4/2019</p>		

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>(continued on next page)</p>

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<p>F 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure kitchen staff used appropriate portioning utensils for food service, which is necessary to provide accurate and consistent meal portions to residents (Resident 12), when one staff member was observed using a regular metal teaspoon instead of standardized portioning utensil to serve cottage cheese during meal preparation. This failure had the potential to result in inconsistent portion sizes and negatively impact residents' nutritional intake and dietary orders. Findings: During an observation on 7/22/25 at 9:32 a.m. with Kitchen Staff (KS) 1, KS 1, was observed preparing cottage cheese and strawberry salads for lunch. KS 1 stated the salads were being prepared to accommodate resident special requests. KS 1 used a small, regular metal spoon to scoop and portion two scoops of cottage cheese into each container, followed by placing approximately 4 to 5 chopped strawberry slices on top. KS 1 then placed the resident label to the top of each container and placed the complete salads on ice for service. During a review of Resident 12'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 12 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), and Hypertension (high blood pressure). During a review of Resident 12's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 7/24/25, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 13 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 13 had no cognitive impairment. During a review of Resident 12's Diet Order dated 7/18/25, the Diet Order indicated Resident 12 was to receive cottage cheese with fruit daily as a morning snack. The order specified this was to support stable weight trends. During a review of Resident special request labels, dated 7/23/25, Resident 12's label indicated he was to receive 8 ounces of cottage cheese and fruit for the morning snack. During an interview on 7/23/25 at 8:33 a.m. with KS 2, KS 2 stated the kitchen has measuring cups, scoops and spoodles (a portion control scoop used for serving and portioning food with accuracy) available for portioning food. KS 2 stated regular spoons should not be used for measuring or serving portions. KS 2 explained it is important to ensure residents receive accurate amounts of certain ingredients, such as salt and protein, to avoid providing too much or too little based on their dietary needs. During an interview on 7/23/25 at 11:40 a.m. with the Registered Dietitian (RD), the RD stated recipes are developed to create a balanced meal and that all ingredients are necessary to maintain nutritional adequacy. The RD stated staff were to use the correct measuring scoop, not a regular spoon, when preparing food. The RD explained using the appropriate portioning tools helps ensure meals remain balanced and residents receive the correct, ordered amounts as specified in their dietary plans. During an interview on 7/23/25 at 3:49 p.m. with KS 3, KS 3 stated she was portioning an ambrosia salad for dinner. KS 3 stated she follows the recipe when portioning food items and that the recipe for ambrosia specified the use of a #8 scoop, which she was using. KS 3 stated staff were not allowed to use a regular spoon when serving and must use the scoop specified in the recipe. KS 3 explained that a #8 scoop is equivalent to 8 ounces or half cup, and that the kitchen maintains a spread sheet that provides the ounces equivalent for each scoop size. KS 3 stated it was important to ensure everyone receives the same portion or the specifically ordered amount to provide correct nutrients. During an interview on 7/23/25 at 4:09 p.m. with the Certified Dietary Manager (CDM), the CDM stated it was his expectation that staff follow recipes as written. The CDM stated KS 1 should have used a #8 scoop twice, equivalent to 8 ounces, when preparing Resident 12's cottage cheese salad. During a review of the facility's policy and procedure (P&P) titled, Food Preparation subject: Standardized Recipes, dated 2023, the P&P indicated, standardized recipes will be used for each item prepared as indicated on the menu. recipes should include b. number and size of portions. During a review of the facility's policy and procedure (P&P) titled, Food Preparation subject: Portion Control, dated 2023, the P&P indicated, Portions served are those listed on the menu for each food item. standard tools are utilized to assure portion control, I.E. scoops, measuring cups, ladles, measuring spoons, standardized recipes and food scale. scoop are sized according to the number of scoops needed to equal one quart. scoop size #8 equals 1/2c.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Based on observation, interview, and record review the facility failed to ensure food was stored, prepared and distributed in accordance with professional standards when:1. Four kitchen staff (KS) employees (KS 4,5, 6 and 7) and the Certified Dietary Manager (CDM) were observed working in the kitchen without wearing beard nets, despite having facial hair.2. Reach in refrigerator was not maintained at 40 degrees Fahrenheit (a way to measure temperature) or below.3. Clean souffle bowls were stored with visible food crumbs and debris on them.4. The stove had visible grease and grime on its surface and behind the unit. The adjacent wire rack, which held bottles of cooking oils and vinegars, had visible grease and food spillage on both the bottles and shelving.5. The chute of the East Wing ice machine, where ice is dispensed, was observed to be soiled with an orange and black substance.The facility's failure to maintain professional standards for food service safety had the potential to expose highly susceptible residents who received food from the kitchen to foodborne illness (an illness that occurs when you eat or drink something contaminated with harmful bacteria, viruses, toxins, or chemicals) due to cross-contamination (bacteria unintentionally transferred from one substance or object to another, with harmful effect).Findings:1. During an observation on 7/22/25 at 9:30 a.m., KS 4 was in the dishwashing area of the kitchen and placed soiled dishes into the high-temperature dishwasher. KS 4 had a goatee and was not wearing a beard net during the observation.During an observation on 7/22/25 at 11:18 a.m., KS 5 was observed in the kitchen checking food temperatures for tray line. KS 5 had a beard and was not wearing a beard net.During an observation on 7/22/25 at 11:25 a.m. KS 4 was observed in the kitchen measuring the temperature of coffee. KS 4 was not wearing a beard net. KS 6 was also observed sweeping the kitchen floor and was not wearing a beard net. KS 6 had a beard and mustache. At the same time, the CDM, who had a goatee, was observing the tray line process and was not wearing a beard net.During an observation on 7/22/25 at 11:39 a.m. hairnets were observed to be stored outside the CDM's office; however, the beard covers were not observed in the same location.During an observation on 7/22/25 at 3:20p.m., KS 7, who had a beard, was observed portioning crab cakes onto baking sheets for dinner meal and was not wearing a beard net. At the same time, KS 6 was observed plating coconut cake for dessert and was also not wearing a beard net.During an interview on 7/22/25 at 3:38 p.m. with Kitchen Lead Supervisor (KLS) 1 and the CDM, KLS 1 stated that it was the expectation for staff with facial hair to wear a beard covering. KLS 1 also stated beard covers were not available in the kitchen at that time. The CDM stated all facial hair should be covered and reported that all kitchen staff with facial hair (including himself) were instructed to leave the kitchen and apply beard nets.During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control subject: Personal Hygiene, dated 2023, indicated Beards and/or mustaches should be covered during meal preparation and service.2. During an observation on 7/22/25 at 9:30, the reach in refrigerator containing apple sauce, mandarin oranges, salads and juices was observed to be 45 degrees.During an observation on 7/22/25 at 11:20 a.m., the reach in fridge was observed to be 46 degrees.During a concurrent observation and interview on 7/22/25 at 11:25 a. m. with the CDM and KLS 2, the CDM and KLS 2 were observed checking the temperature of the reach in refrigerator, removing items from it and placing them into the sliding door refrigerator, which was 40 degrees. The refrigerator was removed from service. The CDM stated refrigerators needed to maintain a temperature of 40 degrees or below.During an interview on 7/22/25 at 3:27 p.m. with the CDM, the CDM stated they were arranging for someone to assess the reach in refrigerator, as the unit was unable to maintain the required temperature when the door was opened. The CDM noted that the door was frequently opened during food service and tray line, which contributed to the issue.During an interview on 7/23/25 at 9:16 a.m. with the CDM, the CDM stated the facility-maintained maintenance request logs for equipment and that staff completed these logs when equipment was not functioning properly.During a review of the Dessert/Salad Reach-In #2 Refrigerator Temperature log dated for the month of July 2025, the Temperature log indicated staff were to check and record the refrigerator temperature at 7:30 a.m., 11:30 a.m., and 4:30 p.m. daily. The review revealed that only on July 13 had the refrigerator temperature recorded at 40 degrees Fahrenheit or below for all three checks. For all other dates through July 22, the temperature was documented above 40 degrees at least one of the three scheduled checks. On July 1, the temperature was recorded 50 degrees for all three checks, and it was noted that the issue had been reported to maintenance.During a review of the Maintenance Log dated 6/24/25 through 7/20/25, the Maintenance Log indicated the only reported kitchen issues were rust in a sink documented on 6/25/25 and a leaky faucet documented on 7/17/25. No</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to observe infection control measures for two of seven sampled residents (Resident 60 and Resident 79) when:1. The Licensed Vocational Nurse (LVN) did not perform hand hygiene after disposing of soiled wound dressing during Resident 60's wound dressing change observation.This failure had the potential to result in cross contamination (bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and transmission of infection between residents, staff and visitors.2. There was no storage bag for Resident 60's nasal cannula (NC- a tube that directs oxygen into the nose).This failure had the potential to result in Resident 60 becoming infected with a virus or bacteria from contaminated (having been made impure by exposure to a substance) oxygen tubing.3. Resident 79's oxygen (O2) NC was found unbagged on top of the resident's bedside table lying next to used tissues, and trash can. This failure had the potential to result in the spread of germs and bacteria that could result in infection and illness.Findings:</p> <p>1. During a review of Resident 60's &ldquo;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)&rdquo;, dated 7/28/25, the &ldquo;AR&rdquo; indicated, Resident 60, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included &ldquo;&hellip;other fracture of lower end of left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, unspecified dementia (a progressive state of decline in mental abilities)&hellip;&rdquo;;</p> <p>During a review of Resident 60's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 6/9/25, the &ldquo;MDS&rdquo;; section C indicated, Resident 60's Brief Interview for Mental Status (BIMS) assessment score was 6 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 60 had severe cognitive deficit.</p> <p>During a concurrent observation and interview on 7/23/25 at 10:53 a.m. outside Resident 60&rsquo;s room, LVN 3 was observed exiting Resident 60&rsquo;s room with soiled dressing in her bare hands after completing a wound dressing change on Resident 60. LVN 3 disposed of the soiled dressing into the trash can at the side of the wound cart and proceeded to move the wound cart without performing hand hygiene. LVN 3 stated &ldquo;I washed my hands in the bathroom and picked up the soiled dressing.&rdquo;; LVN 3 stated &ldquo;I should have cleaned my hands after throwing the soiled dressing away.&rdquo;; LVN 3 stated &ldquo;I could have infected everyone I came in contact with including myself.&rdquo;; LVN 3 stated the importance of maintaining proper hand hygiene is to keep infection under control and ensure there is no cross contamination.</p> <p>During an interview on 7/25/25 at 9:48 a.m. with the Director of Nursing (DON), the DON stated the LVN needed to perform hand hygiene after handling the soiled dressing. The DON stated the importance of performing hand hygiene after handling the soiled dressing would be to prevent infection to others. The DON stated the LVN not performing hand hygiene had the potential to transmit infection to other residents.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 7/25/25 at 10:47 a.m. with the Director of Staff Development (DSD), the DSD stated the expectation would be the LVN should have washed her hands, put gloves on and picked up the soiled dressing, then removed the gloves and performed hand hygiene. The DSD stated hand hygiene was important because someone else would be touching the cart and working with other residents. The DSD stated there could have been transmission of infection to other people.</p> <p>During an interview on 7/25/25 at 1:28 p.m. with the Infection Preventionist (IP), the IP stated the dirty soiled dressing should not have left Resident 60's room. The IP stated the LVN should have put the soiled dressing in the soiled bag before exiting Resident 60's room, then the LVN should have sanitized her hands. The IP stated the LVN's hand was contaminated when she used bare hands to touch the soiled dressing. The IP stated the LVN did not follow the infection control and hand hygiene policies. The IP stated the importance of performing hand hygiene was to prevent spreading infection from resident to resident. The IP stated the actions of the LVN could have resulted in the spread of infections</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (LVN), dated 9/2017, the document indicated . Primary Job Duties &hellip;13. Perform all duties in a safe manner and insures that staff follows infection control procedures and universal precautions in accordance with facility procedures&hellip; Other requirements &hellip;.6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care&hellip;&rdquo;</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (RN), dated 8/2017, the document indicated .Primary Job Duties&hellip;13. Perform all duties in a safe manner and insures that staff follows infection control procedures and universal precautions in accordance with facility procedures. Other requirements &hellip;Other requirements &hellip;.6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care&hellip;&rdquo;</p> <p>During a review of the facility's document titled, Job Description, Director of Nursing, dated 4/2004, the document indicated .2. &hellip; ensures that the policies and procedures are followed&hellip;19. Ensures that nursing staff performs their duties in a safe manner, and follows established isolation, infection control, and universal precautions procedures as instructed&hellip;&rdquo;</p> <p>During a review of the facility's document titled, Job Description, Infection Preventionist, dated 4/2025, the document indicated Purpose: The Infection Preventionist, is responsible for the facility infection prevention and control program (IPCP), which is designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections&hellip;. 1. Oversight of the IPCP, which includes, at a minimum&hellip;the hand hygiene procedures to be followed by staff involved in direct resident contact&hellip;10. Assess the need for, develop, and present IPCP in-service education for individual departments, &hellip; as needed.</p> <p>During a review of the facility's policy and procedure (P&P) titled, &ldquo;Dressings, Dry/Clean&rdquo; dated 2001, the &ldquo;P&P&rdquo; indicated, &ldquo;Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings&hellip;.7. Pull glove over dressing and discard into plastic or biohazard bag &hellip;&rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, "Hand washing/ Hand Hygiene"; revised 8/2015, the "P&P"; indicated, "Policy statement: this facility considers hand hygiene the primary means to prevent the spread of infection. Policy interpretation and implementation . One. All personnel shall be trained and regularly in-serviced on the importance of iron hygiene in preventing the transmission of healthcare associated infections. 2. All personnel shall follow the hand washing/ hand hygiene procedure to help prevent the spread of infection to other personnel, residents, and visitors"; 7. Use an alcohol-based hand rub containing at least 62% alcohol: or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: . g. Before handling cleaning or soiled dressing, gauze pads, etc k. After handling used dressing, contaminated equipment etc";</p> <p>2. During a review of Resident 60'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 7/28/25, the "AR"; indicated, Resident 60, was admitted to the facility on [DATE], was sent out to the hospital and returned to the facility on [DATE]. Resident 60's diagnoses included "congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), hypertensive (high blood pressure) heart disease with heart failure, gastroesophageal reflux disease (GERD- is a digestive disorder where stomach acid frequently flows back into the esophagus, causing heartburn and other symptoms), insomnia (trouble falling asleep or staying asleep), unspecified dementia (a progressive state of decline in mental abilities)";</p> <p>During a review of Resident 60's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 6/9/25, the "MDS"; section C indicated, Resident 60's Brief Interview for Mental Status (BIMS) assessment score was 6 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 60 had severe cognitive deficit.</p> <p>During a concurrent observation and interview on 7/22/25 at 9:31 a.m. with Resident 60 during the initial tour in Resident 60's Room, Resident 60 was lying in bed with eyes closed and a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing) and was set to 2 LPM (liter per minute- a unit of measurement for the flow rate of oxygen). There was no bag to store the NC on the O2 concentrator, wheelchair, bedside table or Resident 60's room.</p> <p>During a concurrent interview and record review on 7/25/25 at 9:48 a.m. with the Director of Nursing (DON), a photo of Resident 60's O2 concentrator and room was reviewed. The DON stated a storage bag is used to store residents' NC tubing. The DON stated every resident on O2 should have a bag to store the O2 mask or NC. The DON validated there was no bag to store NC in Resident 60's room. The DON stated there should have been a bag to store the NC when the NC was not in use. The DON stated the importance of using the bag was to ensure the NC was not hanging on unclean surfaces because of infection control.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a concurrent interview and record review on 7/25/25 at 10:47 a.m. with Director of Staff Development (DSD), a photo of Resident 60's O2 concentrator and room was reviewed. The DSD stated there should be a bag that has a sticky strip that is used to attach the bag to the O2 concentrator or the back of the resident's chair. The DSD stated the NC should be in the bag when not in use. The DSD validated there was no bag on Resident 60's O2 concentrator.</p> <p>During an interview on 7/25/25 at 1:28 p.m. with the Infection Preventionist (IP), the IP stated the expectation would be that all residents on O2 have a bag for storage of the NC when not in use. The IP stated the bag has a sticky strip that goes on the O2 concentrator. The IP stated the importance of having the bag was to prevent the contamination of the tubing and the spread of infection.</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (LVN), dated 9/2017, the document indicated . Primary Job Duties &hellip;16. Participates in overall plan-of-care for each resident. Other requirements &hellip;6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care&hellip;&rdquo;</p> <p>During a review of the facility's document titled, Job Description, Staff Nurse/Charge Nurse (RN), dated 8/2017, the document indicated .Primary Job Duties&hellip;17. Participates in overall plan-of-care for each resident&hellip; Other requirements &hellip;6. Must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulations, and guidelines that pertain to long term care&hellip;&rdquo;</p> <p>During a review of the facility's document titled, Job Description, Director of Nursing, dated 4/2004, the document indicated .2. &hellip; ensures that the policies and procedures are followed&hellip;21. Ensures nursing services and supplies are available and used in an efficient manner &hellip;&rdquo;</p> <p>During a review of the manufacturer's recommended usage for the Wikipouch, the manufacturer indicated, &ldquo;&hellip;2. The Wikipouch is to be secured in close proximity for easy access. 3. The Wikipouch can be adhered to oxygen concentrators, wheelchairs and bedside tables&hellip;4. To protect the patients, staff and the facility from cross contamination, always store Nasal Cannulas&hellip; inside the WikiPouch when not in use.</p> <p>During a review of a professional reference from https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection titled Don't Let an Oxygen Concentrator Lead to Infection, Dated 1/2020, the professional reference indicated, .2 In Use Nasal Cannula . For patients switching to portable oxygen or pro re nata home oxygen administration, nasal cannula storage can be problematic. The nasal cannula prongs often become contaminated when patients don't properly protect the cannula between uses (i.e., leaving the nasal cannula on the floor, furniture, bed linens, etc.). Then the patient puts the contaminated nasal cannula back in their nostrils and directly transfers potentially pathogenic organisms from these surfaces onto the mucous membranes inside their nasal passages, putting them at risk of developing a respiratory infection. Educate the patient on how to store the nasal cannula between uses in a manner that does not allow it to have direct contact with potentially contaminated surfaces. Either keep the in-use nasal cannula somewhere that does not allow contact with a surface or place it on a clean surface, inside an open clean container, or in an open plastic bag .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>3. During observation of Resident 79 in Resident 79's room on 7/22/25 at 4:20 p.m. O2 NC tubing was seen not in use and not in bag the tubing was laying on top of the bedside table agents used tissue and trash can.</p> <p>During a review of Resident 79's "AR" dated 7/25/25, the "AR" indicated, Resident 79 was initially admitted to the facility on [DATE] with diagnoses of Morbid Obesity (a severe form of obesity characterized by an extremely high body mass index [BMI]), hypertension (HTN- high blood pressure) and gastroesophageal reflux disease ([GERD] is a digestive disorder where stomach acid frequently flows back into the esophagus, causing heartburn and other symptoms).</p> <p>During a review of Resident 79's "Order Summary Report (OSR)" dated 7/17/25, the "OSR" indicated, "Oxygen- At 2 liters (unit of measurement) per/minute via Nasal cannula prn (as needed) shortness of breath .</p> <p>During a review of Resident 79's "MDS, dated [DATE], the "MDS" section C indicated Resident 79 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 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 79 was cognitively intact.</p> <p>During a concurrent observation and interview on 7/23/25 at 9:29 a.m. with Certified Nursing Assistant (CNA) 6 stated when tubing is not in use the tubing is placed in a bag to keep clean. CNA 6 stated that nurses and or CNAs can take the NC off the resident and place in the bag, this is done for infection control.</p> <p>During an interview on 7/24/25 at 1:44 p.m. with LVN 1, LVN 1 stated the O2 tubing should not have been left out on top of the bedside table. LVN 1 stated the tubing is changed out weekly and should have been labeled with a date. LVN 1 stated the O2 tubing should have been placed into the bag when not in use. LVN 1 stated cross contamination could have occurred and by having it dated to indicate the NC was changed.</p> <p>During an interview on 7/25/25 at 10:29 a.m., with the Infection Preventionist (IP), the IP stated the NC are stored in the central supply, and a labeled bag is provided for the NC storage when not in use. The IP stated staff are to store the NC in the (Wiki pouch) bag with a sticker indicating the date changed. The IP stated the NC is changed weekly by the night shift, and the staff are educated not to leave it out when not in use. The IP reviewed a photo of Resident 79's NC lying on the bedside table and stated the NC was resting on a high touch surface and the tubing would need to be replaced. The IP stated leaving the NC exposed and not properly stored poses a risk of contamination and infection. The IP stated this was not consistent with the facility's policy for oxygen administration.</p> <p>During an interview on 7/29/25 at 9:10 a.m. the DON, the DON stated it was the expectation of the facility to store the NC in the designed storage bag when not in use. The DON stated the tube must be changed weekly. The [NAME] stated failure to store respiratory equipment properly could result in contamination and did not align with facility expectation. The DON stated staff were trained in proper storage procedures to prevent infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During a review of the facility's policy and procedure (P&P) titled, "Infection Control-Respiratory Care," undated, the P&P indicated, "Changes are to be documented in the patient's chart & O2 set up is to be labeled with date and time";</p> <p>During a review of the manufacturer's recommended usage for the Wikipouch, the manufacturer indicated, "to protect the patients, staff and the facility from cross contamination, always store Nasal Cannulas inside the WikiPouch when not in use.</p> <p>During a review of a professional reference from https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection titled "Don't Let an Oxygen Concentrator Lead to Infection, Dated 1/2020, the professional reference indicated, "In Use Nasal Cannula . For patients switching to portable oxygen or pro re nata home oxygen administration, nasal cannula storage can be problematic. The nasal cannula prongs often become contaminated when patients don't properly protect the cannula between uses (i.e., leaving the nasal cannula on the floor, furniture, bed linens, etc.). Then the patient puts the contaminated nasal cannula back in their nostrils and directly transfers potentially pathogenic organisms from these surfaces onto the mucous membranes inside their nasal passages, putting them at risk of developing a respiratory infection. Educate the patient on how to store the nasal cannula between uses in a manner that does not allow it to have direct contact with potentially contaminated surfaces. Either keep the in-use nasal cannula somewhere that does not allow contact with a surface or place it on a clean surface, inside an open clean container, or in an open plastic bag .</p>		