STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555530	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chowchilla Memorial Healthcare District	1104 Ventura Ave. Chowchilla, CA 93610

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (CP - a detailed approach to care customized to an individual resident's needs) for two of 12 sampled residents (Resident 12 and Resident 78) when: 1. There was no CP created addressing Resident 12's diagnosis of Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe.) 2. Resident 78 had a care plan for fluid overload (a person has too much fluid, potentially causing swelling, shortness of breath, and high blood pressure) related to kidney failure (when the kidneys stop working properly, leading to a buildup of waste in your blood, which can be dangerous if left untreated), but there was not a comprehensive assessment that reflected the medical issue. These failures had the potential to prevent Resident 12 and Resident 78 from receiving appropriate, and individualized care and services consistent with their needs. Findings: 1. During a review of Resident 12's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 11/28/23, the AR indicated, Resident 12 was admitted from the acute care hospital on 9/27/24 to the facility, with diagnoses that included COPD, Muscle Weakness, Hypertension (high blood pressure), Cerebral Infarction (stroke- loss of blood flow to part of the brain), and Schizophrenia (chronic and severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others). During a review of Resident 12's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 1/10/25, the MDS indicated Resident 12's Brief Interview for Mental Status (BIMS) score was 15 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact). (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/19/25 at 10:50 a.m., with Resident 12 inside his room, Resident 12 was observed lying in bed, covered with a light white sheet and head of bed was elevated about 30 degrees. Resident 12 stated he has a diagnosis of COPD and takes routine and as needed medication (PRN) to improve his breathing. Resident 12 stated he uses an inhaler whenever he experienced sudden shortness of breath. During a concurrent interview and record review on 2/19/25 at 3:30 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 12's Physician Order Summary (POS), and Care Plan (CP), undated, were reviewed. The POS indicated, . Fluticasone Furoate-Vilanterol [medication used to control wheezing (high pitch whistling sound), shortness of breath (SOB), and chest tightness] 100-25 [MCG (microgram-unit of measurement) /ACT (actuation-the action of causing a machine or device to operation] () one puff inhale orally one time a day for COPD . Order Date 9/30/24 . Albuterol Sulfate Inhalation [medication used to treat breathing problems related to COPD and other respiratory issues] 108 MCG/ACT 2 puff inhale orally every six hours as needed for SOB or wheezing . LVN 1 stated there was no care plan developed and implemented for Resident 12's diagnosis of COPD. LVN 1 stated licensed nurses should care plan the COPD diagnosis so all nursing staff (caring for the resident) would know the plan of care for the resident and to ensure Resident 12 received the appropriate interventions. LVN 1 stated, the facility failed to follow the facility's policy and procedure (P&P) related to care planning process. During a concurrent interview and record review on 2/20/25 at 10:32 a.m., with the Director of Nursing (DON), Resident 12's POS and CP, undated, were reviewed. The DON stated a resident specific care plan should have been developed to address Resident 12's diagnosis of COPD and it was not done. The DON stated the CP was a form of communication with other team members, without a resident specific CP, the staff do not have a clear path to meet Resident 12's medical, physical, mental, and psychosocial needs. The DON stated the failure could potentially result in Resident 12's COPD to worsen. During a review of the facility's policy and procedure (P&P) titled, Care Planning, dated 4/24, the P&P indicated, . Care, treatment and services are planned to ensure they are appropriate to the resident's needs . Within seven (7) days of completion of the comprehensive assessments, all residents shall have a computerized plan of care generated by the Registered Nurse or the Licensed Practical/Vocational Nurse . The plan of care shall be individualized, based on the diagnosis, resident assessment and personal goals of the resident and his/her family . During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Essential Job Functions include, but are not limited to the following . Assessment of Residents . Following all facilities Policies and Procedures . Perform other duties as requested . 2. During a review of Resident 78's Admission Record, dated 2/21/25, the Admission Record indicated, Resident 78 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked), history of endocarditis (a serious inflammation of the heart's inner lining. It's usually caused by a bacterial infection [when tiny, harmful bacteria enter your body, multiply, and cause illness], but can also be caused by fungi [microorganisms that can cause infections]), acute embolism a sudden blockage in a blood vessel, often caused by a blood clot (or other substance) that travels from somewhere else in the body and gets lodged, potentially cutting off blood flow and oxygen to an organ or tissue) and thrombosis (the blockage of a blood vessel by a blood clot) and hypotension (low blood pressure). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's MDS assessment, dated 1/16/25, the MDS assessment indicated Resident 78's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 78 was cognitively intact. During a review of Resident 78's Care Plan, dated 2/4/25, the Care Plan indicated, .Description: The resident has fluid overload or potential fluid volume overload related to Kidney Failure [when the kidneys stop working properly, leading to a buildup of waste in your blood, which can be dangerous if left untreated] . Goal: The resident will comply with diet and/or fluid restrictions [a patient can only have a certain amount of liquid each day] daily through review date . During a review of Resident 78's Admission History and Physical (H&P), dated 2/4/25, the H&P indicated, . Chief Complaint: Patient is admitted for rehab status post transfer (moving a patient from one place to another all while ensuring their medical care continues smoothly) from skilled nursing facility . status post transfer hospitalization for cerebrovascular accident due to arterial septic emboli [infected blood clots that travel through the bloodstream and can block blood vessels, potentially causing damage to tissues or organs] . [AGE] year old male with past medical history significant for thrombophilia [a condition that makes your blood more likely to form clots] . osteomyelitis [a bone infection that causes inflammation and swelling], endocarditis and septic arterial embolism and generalized weakness is admitted for rehab . Physical Exam: . Blood pressure 109/61 . Pulse: 75 . Respirations: 16 . chest (lungs): clear breath sounds bilaterally (both sides) . Cardiovascular (heart): . normal rate and rhythm . During a review of Resident 78's MDS Section I- Active Diagnosis (AD), dated 2/14/25, the AD indicated, . Primary Medical Condition: Cerebral Infarction . Heart/Circulation: Coronary artery disease [a heart condition that occurs when the coronary arteries narrow or become blocked]- No . Heart Failure [a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs]- No . Peripheral vascular disease [a circulatory condition that occurs when blood vessels narrow, block, or spasm]- No . Genitourinary [urinary and genital organs]: Renal insufficiency [kidneys aren't working as well as they should, potentially leading to a buildup of waste and excess fluid in your body], renal failure [kidneys aren't working properly, leading to a buildup of waste and fluid in your body], End stage Renal Disease [kidneys aren't working properly, leading to a buildup of waste and fluid in your body]- No . Pulmonary [Lungs]: Asthma or chronic lung disease- No . Respiratory Failure- No . During a review of Resident 78's Nursing Weekly Summary (NWS), dated 2/8/25, the NWS indicated, . Edema (swelling): No . Respiratory Status: Breath sounds: Clear, Both .Shortness of breath: None . During a review of Resident 78's Lab Results Report (LRR), dated 1/2/25, the LRR indicated, .BUN [urea nitrogen a test that measures the amount of a waste product (urea nitrogen) in your blood which is formed when your body breaks down protein, and your kidneys filter it out]: 18 [milligrams per deciliter- unit of measurement], Reference Range 7 - 25 mg/dl . Creatinine [a waste product in the blood that indicates how well your kidneys are working]: 0.69 mg/dl, Reference Range: .70 -1.30 mg/dl . eGFR [Estimated Glomerular Filtration Rate. It is a measure of how well your kidneys are filtering waste products from your blood] 96 ml/min (milliliters per minute) >= [greater than or equal too] 60 ml/min . Interpretation of eGFR: 60 or more mildly reduced (60 - 89) or Normal (90 or more) . [less than] 15 ml/min [means] Kidney Failure . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/20/25 at 10:19 a.m., with the Licensed Vocational Nurse (LVN) 1, Resident 78's Electronic Medical Record (EMR) dated 2/3/25 to 2/20/25 was reviewed. The EMR indicated Resident 78 had a care plan in place related to kidney failure, but no medical diagnosis or evidence in the record to support that. The LVN 1 stated there was no evidence of edema, fluid overload, nor kidney failure for Resident 78 in the EMR. During an interview on 2/20/25 at 11:30 a.m., with the Registered Dietician (RD), the RD stated Resident 78 did not have any kidney conditions as a diagnosis. During an interview on 2/20/25 at 3:46 p.m., with the RD, the RD stated she looked at Resident 78's labs and did not see anything that would have warranted a fluid restriction or kidney failure. The RD stated she was not sure of the root cause for the fluid restriction that was mentioned in the care plan. During an interview on 2/20/25 at 4:24 p.m., with the DON, the DON stated Resident 78 did not have a diagnosis of a kidney problem. The DON stated a care plan should be based off of diagnosis and resident needs and Resident 78's care plan was not. During an interview on 2/21/25 at 9:59 a.m., with the Director of Staff Development (DSD- also the Infection Preventionist and LVN 2), the DSD stated she created the care plan for Resident 78. The DSD stated she was not sure the reason for the fluid restriction initially and was assuming to get the care plan completed. The DSD stated she put kidney failure without looking ahead and Resident 78 did not have evidence of kidney failure. The DSD stated the care plan was inaccurate in regard to fluid restriction and the kidney failure. The DSD stated care plans should be individualized and Resident 78's was not. The DSD stated the inaccuracy of the care plan would equate to care for Resident 78 not going to be correct. The DSD stated the policy and procedure (P&P) Care Planning was not followed. During an interview on 2/21/25 at 2:09 p.m., with the DON, the DON stated care plans are for staff to provide continuity of care to the resident and the continuity of care was not there. The DON stated, she felt staff followed the P&P Care Planning. The DON stated, that was her opinion. The DON stated there were no assessments, nor objective evidence, in the EMR that indicated kidney failure. During an interview on 2/24/25 at 10:37 a.m., with LVN 1, LVN 1 stated care plans tell us how to care for the resident and keeps them stable. LVN 1 stated a potential outcome for having a care plan that was not based off of comprehensive assessment could have been a risk of injury due to inappropriate medical treatment. LVN 1 stated the P&P Care Planning was not followed by staff. During a review of the facility's P&P titled, Care Planning, dated 4/2024, the P&P indicated, .Policy: Care, treatment and services are planned to ensure they are appropriate to the resident needs . care planning will be implemented through the integration of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable . the plan of care shall be individualized, based on diagnosis, resident assessment . care planning is based on data collected from resident assessments with integration of those assessment findings in the care planning process . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a 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 . During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition . 51620

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 44899 Based on interview and record review, the facility failed to ensure services provided met professional standards of quality for two of 12 sampled residents (Resident 10 and Resident 22) when: 1. Resident 10's pharmacy recommendation to obtain Serum (blood test) B-12 (a vitamin essential for maintaining healthy red blood cells, nerves, and brain function), Creatinine Level (a blood test to check for the kidney's function), Liver Function (a blood test to check for liver's function) and BMP (Basic Metabolic Panel-measures various substances in the blood, including blood sugar and bone health) was not communicated to the Hospice provider. This failure had the potential to place Resident 10 at risk of receiving treatment or procedures against his wishes. 2. Resident 22's pharmacy recommendation to rinse mouth with water and spit back into cup after use of Budesonide-Formoterol Fumarate Dihydrate inhaler (medication used to control shortness of breath (SOB) and chest tightness) was not implemented. This failure had the potential to place Resident 22 at risk of developing oral thrush (a type of mouth infection). Findings: 1. During a review of Resident 10's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/21/25, the AR indicated, Resident 10 was admitted from an acute care hospital on 1/19/24 to the facility, with diagnoses that included Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Hypertension (high blood pressure), Cerebral Infarction (stroke-bleeding inside the brain), and Type 2 Diabetes Mellitus (high blood sugar). During a review of Resident 10's Physician Order Summary Report (POS), dated 2/21/25, the POS indicated, . admitted under the care of [Name of Hospice Agency] . Order Date 1/19/24 . Do Not Resuscitate [DNR-a legal document that instructs medical professionals not to perform resuscitation (artificial breathing) if a patient's breathing or heart stops] . During a concurrent interview and record review on 2/21/25 at 9:22 a.m., with the Director of Nursing (DON), Resident 10's Progress Note (PN), undated, and Resident 10's Pharmacy Monthly Medication Review Recommendation (MRR), dated 1/28/25 were reviewed. The MRR indicated, . patient is receiving Metformin (medication to control blood sugar level) 500 [milligram (mg) - unit of measurement] daily, which may deplete (reduce) vitamin B-12 and has the potential to cause lactic acidosis (excess amount of lactic acid in the blood, causing nausea, vomiting, exhaustion, fatigue and body aches). Please consider ordering a serum B-12 level as baseline and annually to monitor therapy, as well as serum creatinine level, liver function and BMP every 6 months . The DON stated she does not have any record the pharmacy recommendation was forwarded to the Hospice agency for review. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a phone interview and record review, on 2/21/25 at 1:54 p.m., with the Hospice Director of Patient Care Services (HDPCS), Resident 10's Hospice Clinical Record (HCR), dated 2/21/25 was reviewed. The DPCS stated Resident 10 was under Hospice care since 1/19/24 and they worked closely with the facility staff to meet Resident 10's physical, emotional, and spiritual needs. The DPCS stated they did not have any record of pharmacy recommendations to obtain various laboratory tests, otherwise they would act on it. During a concurrent interview and record review, on 2/21/25 at 5:05 p.m., with the DON, the facility's Hospice Program Policy and Procedure (P&P), dated 7/17 was reviewed. The P&P indicated, . 9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness [a condition with no treatment] and related conditions . c. Providing medical direction, nursing, and clinical management of the terminal illness . 12. Our facility has designated [blank space] to coordinate care provided to the resident by our facility staff and the hospice staff . The DON stated she does not have any record or proof that the facility staff communicated the pharmacy recommendation to the hospice agency. The DON stated, If it's not documented, it didn't happen. During a concurrent interview and record review, on 2/24/25 at 11:29 a.m., with the Director of Staff Development (DSD, also the Infection Preventionist [IP] and Licensed Vocational Nurse [LVN] 2), Resident 10's Progress Note (PN), dated 2/24/25 and Physician Order Summary (POS), dated 2/24/25 were reviewed. The DSD stated she does not have any record the pharmacy recommendation was forwarded to the Hospice agency for review. The DSD stated Resident 10 could potentially receive treatment or procedures against his wishes. During a review of the facility's P&P titled, Charting and Documentation, dated 7/17, the P&P indicated, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 7. Documentation of procedures and treatments will include care-specific details, including . date and time of the procedure/treatment was provided . name and title of individual(s) who provided the care . During a review of the facility's document titled, Job Description: Charge Nurse Licensed Vocational Nurse (LVN), dated 8/2015, the document indicated, . Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices . 2. During a review of Resident 22's AR, dated 2/21/25, the AR indicated, Resident 22 was admitted from an acute care hospital on 6/1/23 to the facility, with diagnoses that included Chronic Obstructive Pulmonary Disease (COPD-is a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Hypertension (high blood pressure), and Respiratory Failure (a serious condition that makes it difficult to breathe). During a review of Resident 22's POS, dated 2/21/25, the POS indicated, . Budesonide-Formoterol Fumarate Dihydrate [medication used to control shortness of breath (SOB) and chest tightness] 160-4.5 MCG (microgram-unit of measurement) /ACT (actuation-the action of causing a machine or device to operation] one puff inhale orally two times a day for COPD . Order Date 6/1/24 . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review, on 2/21/25 at 9:26 a.m., with the Director of Nursing (DON), Resident 22's Medication Administration Record (MAR), dated 2/21/25 and MRR, dated 1/28/25 were reviewed. The MRR indicated, . This Resident is receiving Budesonide-Formoterol Fumarate Dihydrate. Steroid inhalers can cause oral thrush which may be minimized by rinsing the mouth with water after each dose of the inhaler. Please consider adding the following verbiage to the order as a reminder: Rinse mouth with water and spit back into cup after use . The DON stated she does not have any record the pharmacy recommendation was noted and acted upon by the facility. The DON stated, If it's not documented, it didn't happen. The DON stated Resident 22 could potentially develop oral thrush from using the inhaler and not rinsing her mouth with water after medication administration. During a concurrent interview and record review, on 2/24/25 at 11:34 a.m., with the Infection Preventionist (IP, also the Director of Staff Development [DSD] and Licensed Vocational Nurse [LVN] 2), Resident 22's MRR, dated 1/28/25 and MAR, dated 2/24/25 were reviewed. The DSD stated she does not have any record the pharmacy recommendation was acknowledged and acted upon by the facility. The DSD stated Resident 22 could potentially develop oral infection from using oral inhalers. During a review of the facility's P&P titled, Medication Regimen Review and Reporting, dated 1/07, the P&P indicated, . Medication Regimen Review (MRR) or Drug Regimen Review is a thorough evaluation of the medication regimen of a resident, with a goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication . During a review of the facility's P&P titled, Charting and Documentation, dated 7/17, the P&P indicated, . All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care . 7. Documentation of procedures and treatments will include care-specific details, including . date and time of the procedure/treatment was provided . name and title of individual(s) who provided the care . During a review of the facility's document titled, Job Description: Charge Nurse Licensed Vocational Nurse (LVN), dated 8/2015, the document indicated, . Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on interview and record review, the facility failed to manage and monitor the quality of care for one of 12 sampled residents (Resident 78), when the facility unjustly implemented a fluid restriction on Resident 78 without a clinical justification (diagnosis or medical need), comprehensive assessment or person-centered care plan. This failure had the potential for harm, including dehydration (occurs when your body loses more fluids than it takes in, leading to a lack of water and other vital fluids needed for normal bodily functions and could lead to a medical emergency) and electrolyte imbalance (having too much or too little of certain minerals (electrolytes) in your body, which can disrupt vital functions like muscle and nerve function, and fluid balance), for Resident 78 due to withholding fluid from him since admittance to the facility on [DATE]. Findings: During a review of Resident 78'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), dated 2/21/25, the Admission Record indicated, Resident 78 was admitted to the facility on [DATE] with a diagnosis of cerebral infarction (a type of stroke that occurs when blood flow to the brain is blocked), history of endocarditis (a serious inflammation [the body's response to injury, infection, or irritation] of the heart's inner lining. It's usually caused by a bacterial infection [when tiny, harmful bacteria enter your body, multiply, and cause illness], but can also be caused by fungi[microorganisms (tiny living things (like bacteria, fungi, and some algae) that are too small to see with the naked eye and require a microscope to be observed) that can cause infections]), acute embolism (a sudden blockage in a blood vessel, often caused by a blood clot (or other substance) that travels from somewhere else in the body and gets lodged, potentially cutting off blood flow and oxygen to an organ or tissue) and thrombosis (the blockage of a blood vessel by a blood clot) and hypotension (low blood pressure). During a review of Resident 78's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 1/16/25, the MDS assessment indicated Resident 78's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 15 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 78 was cognitively intact. During a review of Resident 78's Order Audit Report ([NAME]), dated 2/20/25, the [NAME] indicated, .Order date: 2/3/25 at 12:08 p.m. Order Status: Active . Order Summary: Fluid restriction 1500 [milliliters (mL)- unit of measurement]/24 hours: Dietary 240 mL with breakfast, 240 mL with lunch, 240 mL with dinner. 260 mL each shift given by nursing staff . created by: Licensed Vocational Nurse [LVN] 2 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 78's Care Plan, dated 2/4/25, the Care Plan indicated, .Description: The resident has fluid overload [a person has too much fluid, potentially causing swelling, shortness of breath, and high blood pressure] or potential fluid volume overload related to Kidney Failure [when the kidneys stop working properly, leading to a buildup of waste in your blood, which can be dangerous if left untreated] . Goal: The resident will comply with diet and/or fluid restrictions [a patient ordered to have a certain amount of liquid each day] daily through review date . During a review of Resident 78's Admission History and Physical (H&P), dated 2/4/25, the H&P indicated, . Chief Complaint: Patient is admitted for rehab status post transfer [moving a patient from one place to another all while ensuring their medical care continues smoothly] from skilled nursing facility . status post transfer hospitalization for cerebrovascular accident [a medical emergency where blood flow to the brain is suddenly interrupted, either by a blockage or a rupture of a blood vessel, leading to potential brain damage] due to arterial septic emboli [infected blood clots that travel through the bloodstream and can block blood vessels, potentially causing damage to tissues or organs] . [AGE] year old male with past medical history significant for thrombophilia [a condition that makes your blood more likely to form clots] . osteomyelitis [a bone infection that causes inflammation and swelling], endocarditis and septic arterial embolism and generalized weakness is admitted for rehab . Physical Exam: . Blood pressure 109/61 . Pulse: 75 . Respirations: 16 . chest (lungs): clear breath sounds bilaterally [both sides] . Cardiovascular [heart]: . normal rate and rhythm . During a review of Resident 78's MDS Section I- Active Diagnosis (AD), dated 2/14/25, the AD indicated, . Primary Medical Condition: Cerebral Infarction . Heart/Circulation: Coronary artery disease [a heart condition that occurs when the coronary arteries narrow or become blocked]- No . Heart Failure [a chronic condition that occurs when the heart can't pump enough blood to meet the body's needs]- No . Peripheral vascular disease [a circulatory condition that occurs when blood vessels narrow, block, or spasm]- No . Genitourinary [urinary and genital organs]: Renal insufficiency [kidneys aren't working as well as they should, potentially leading to a buildup of waste and excess fluid in your body], renal failure [kidneys aren't working properly, leading to a buildup of waste and fluid in your body], End stage Renal Disease [kidneys aren't working properly, leading to a buildup of waste and fluid in your body]- No . Pulmonary [Lungs]: Asthma [a chronic lung disease that makes breathing difficult] or chronic lung disease [damage to the lungs or airway]- No . Respiratory Failure- No . During a review of Resident 78's Nursing Weekly Summary (NWS), dated 2/8/25, the NWS indicated, . Edema [swelling]: No . Respiratory Status: Breath sounds: Clear, Both .Shortness of breath: None . During a review of Resident 78's Lab Results Report (LRR), dated 1/2/25, the LRR indicated, .BUN [urea nitrogen a test that measures the amount of a waste product (urea nitrogen) in your blood which is formed when your body breaks down protein, and your kidneys filter it out]: 18 [milligrams per deciliter (mg/dl)- unit of measurement], Reference Range 7 - 25 mg/dl . Creatinine [a waste product in the blood that indicates how well your kidneys are working]: 0.69 mg/dl, Reference Range: .70 -1.30 mg/dl . [Estimated Glomerular Filtration Rate (eGFR) - a measure of how well your kidneys are filtering waste products from your blood] 96 [milliliters per minute ml/min] [greater than or equal to] 60 ml/min . Interpretation of eGFR: 60 or more mildly reduced (60 - 89) or Normal (90 or more) . [less than] 15 ml/min [means] Kidney Failure . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 78's Progress Note (PN), dated 2/21/25, the PN indicated, .Subjective: Evaluation for fluid restriction . Problem list: Cerebral infarction with right hemiparesis (right side of body weakness), thiamine deficiency [a person's body doesn't get enough thiamine, which is vital for converting food into energy and maintaining healthy nerves, muscles, and the heart], essential hypertension, acute thromboembolism [the blockage of a blood vessel by a blood clot], endocarditis, heart valve disorder, chronic pain syndrome . Objective: he is in no acute distress. Vital signs: blood pressure 98/61 [millimeters of mercury (mmHg) -unit of measurement] . pulse [heartrate]: 79, respirations 18, saturation 90% on ambient air [room air] . There is no volume overload . Assessment: Cerebral infarction unspecified, thiamine deficiency, hyperlipidemia, essential hypertension, use of fluid restriction not clear . Plan and Management: . 2. Discontinue fluid restriction for one week. Repeat basic metabolic panel after one week . During a concurrent interview and record review on 2/20/25 at 10:19 a.m., with the Licensed Vocational Nurse (LVN) 1, Resident 78's Electronic Medical Record (EMR), dated 2/3/25 to 2/20/25 was reviewed. The EMR indicated Resident 78 had a care plan in place related to kidney failure, but no medical diagnosis or evidence in the record to support that. The LVN 1 stated he was the nurse responsible for Resident 78 today. LVN 1 stated there was no evidence of edema, fluid overload, nor kidney failure for Resident 78 in the EMR. LVN 1 stated there had not been any issues with Resident 78's physical exams since he had been at their facility. During an interview on 2/20/25 at 11:30 a.m., with the Registered Dietician (RD), the RD stated Resident 78 did not have any congestive heart failure (a serious condition that occurs when the heart can't pump enough blood to meet the body's needs) or kidney conditions as a diagnosis in the EMR. During an interview on 2/20/25 at 3:46 p.m., with the RD, the RD stated she looked at Resident 78's labs and did not see anything that would have warranted a fluid restriction or kidney failure referenced in the care plan. The RD stated Resident 78 was admitted with the fluid restriction order but could not find a medical reason for it. The RD stated she was not sure of the root cause for the fluid restriction that was ordered. During an interview on 2/20/25 at 4:24 p.m., with the Director of Nursing (DON), the DON stated Resident 78 did not have a diagnosis of a kidney problem. The DON stated a care plan should be based off of diagnosis and resident needs and Resident 78's care plan was not. The DON stated the facility was still in the process of investigating why Resident 78 was put on a fluid restriction at his previous facility. The DON stated the orders from the previous facility were kept at this facility and the fluid restriction was part of that. The DON stated Resident 78 had been on the fluid restriction since his admit to this facility on 2/3/25 but did not know who originally ordered the fluid restriction or why. During an interview on 2/21/25 at 9:59 a.m., with the Director of Staff Development (DSD- also the Infection Preventionist and LVN 2), the DSD stated she created the care plan for Resident 78. The DSD stated she was not sure the reason for the fluid restriction initially and was assuming to get the care plan completed. The DSD stated she put kidney failure without looking ahead and Resident 78 did not have evidence of kidney failure. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DSD stated the care plan was inaccurate in regard to fluid restriction and the kidney failure. The DSD stated care plans should be individualized and Resident 78's was not. The DSD stated the inaccuracy of the care plan would equate to care for Resident 78 not going to be correct. The DSD stated the policy and procedure (P&P) Care Planning was not followed. The DSD stated Resident 78 came with that fluid restriction order from another facility. The DSD stated the facility tried to obtain past medical records from previous hospital stays and doctor appointments to find the origin of the fluid restriction, but they did not currently have them. The DSD stated this was not good quality of care and Resident 78 could have potentially been dehydrated because of the order. During an interview on 2/21/25 at 2:09 p.m., with the DON, the DON stated care plans are for staff to provide continuity of care to the resident and the continuity of care was not there. The DON stated, she felt staff followed the P&P Care Planning. The DON stated, that was her opinion. The DON stated there were no assessments, nor objective evidence, in the EMR that indicated kidney failure. The DON stated the facility tried to be cautious with Resident 78 and that is why they kept the fluid restriction order from the previous facility. The DON stated after private review of the EMR, the fluid restriction was not a safe order for Resident 78 to be on and it was not justified. The DON stated there was not a current clinical indication, no physical exam or current diagnosis, on why Resident 78 should have had a fluid restriction order. The DON stated the fluid restriction was incorrect and a mistake. During an interview on 2/21/25 at 3 p.m., with Medical Doctor (MD) 1, MD 1 stated the Medical Director was on vacation and the facility called him to assess Resident 78. MD 1 stated he assessed Resident 78 today and completed a physical assessment which was normal. MD 1 stated Resident 78's lungs were not wet, not short of breath, no edema and nothing indicates a fluid restriction was needed. MD 1 stated Resident 78 did not have an active diagnosis of congestive heart failure or kidney issues and there were no problems in terms of fluid. MD 1 stated people make mistakes and we learn from them. During an interview on 2/21/25 at 4:57 p.m., with the DSD, the DSD stated there was no objective evidence, nor clinical reason, for Resident 78's fluid restriction. During an interview on 2/24/25 at 10:37 a.m., with LVN 1, LVN 1 stated care plans tell us how to care for the resident and keeps them stable. LVN 1 stated a potential outcome for having a care plan that was not based off of comprehensive assessment could have been a risk of injury due to inappropriate medical treatment. LVN 1 stated the P&P Care Planning was not followed by staff. LVN 1 stated Resident 78 did not have a comprehensive or current assessment that justified why he requireda fluid restriction order. LVN 1 stated potential outcomes would be Resident 78 not getting proper care and dehydration. LVN 1 stated Resident 78 was also denied the freedom of his choices due to not being able to drink however much he desired. LVN 1 stated there was no medical rationale, no congestive heart failure, end stage renal disease, nor acute kidney injury that would warrant the fluid restriction. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Planning, dated 4/2024, the P&P indicated, .Policy: Care, treatment and services are planned to ensure they are appropriate to the resident needs . care planning will be implemented through the integration [the process of combining or uniting separate things into a whole] of assessment findings, consideration of the prescribed treatment plan and development of goals for the resident that are reasonable and measurable . the plan of care shall be individualized, based on diagnosis, resident assessment . care planning is based on data collected from resident assessments with integration of those assessment findings in the care planning process . During a review of National Institute of Health.gov Professional Reference title, Fluid Management, dated October 2023, found at (https://www.ncbi.nlm.nih.gov/books/NBK532305/#:~:text=Clinical%20Significance, help%20alleviate%20these%20potential%20problems.), the reference indicated, .Fluid management is crucial in inpatient medical settings, where each patient presents unique and individual requirements . Improper fluid management can cause significant morbidity [disease] and mortality [death] from volume [amount of fluid] depletion [lack of] or overload. Therefore, it is essential to carefully assess the specific type and quantity of fluids required for each patient . crucial role of the interprofessional healthcare team in managing patients' volume status, optimizing patient outcomes and reducing morbidity and mortality . Objectives: . Implement evidence-based fluid resuscitation and maintenance therapy guidelines for acute and critical care patients, considering their unique physiological needs . Identify potential risk factors and contraindications [a reason why a specific medical treatment or procedure shouldn't be used because it could be harmful to a person] related to fluid management in patients . Communicate effectively among the interprofessional healthcare team, including physicians, nurses, nutritionists, and pharmacists, to optimize fluid management strategies and improve patient outcomes . Treatment: . Assessment of vital signs, physical examinations, and supplementary laboratory data will help determine the appropriateness of each patient's fluid management strategy . During a review of Joint Commission.org Professional Reference title, Medication Order- Indication for Use Requirements, dated November 2021, (found at https://www.jointcommission. org/standards/standard-faqs/home-care/record-of-care-treatment-and-services-rc/000001696/), the reference indicated, .Does the medical record need to contain a diagnosis, condition, or indication for use for each medication ordered? . Yes. Standard MM.04.01.01 requires that there be documented indication for all medications ordered. That indication can be in the form of lab values, diagnoses, progress note entries, etc. In other words, the indication must be evident somewhere in the medical record. This requirement is found in the Medication Management chapter at MM.04.01.01. 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 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/), the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum . vital to positive patient outcomes . the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 10) was free from accidents, when Resident 10 was smoking and had ashes fall on his shirt and into his wheelchair. This failure placed Resident 10's safety at risk and the ashes had the potential to burn the resident. Findings: During a review of Resident 10'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), dated 2/21/25, the Admission Record indicated, Resident 10 was admitted to the facility on [DATE] with a diagnosis of Dementia (a brain condition that causes memory loss, thinking problems, and behavioral changes), Cerebrovascular Accident (a medical emergency where the blood supply to the brain is suddenly interrupted, either by a blockage or a rupture of a blood vessel, leading to brain damage) and senile degeneration of brain (a decline in brain function, often associated with aging, that can lead to memory loss, difficulty with thinking and problem-solving, and changes in behavior). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 2/10/25, the MDS assessment indicated Resident 10's Brief Interview for Mental Status (BIMS -assessment of cognitive status for memory and judgment) assessment score was 5 out of 15 (a score of 13-15 indicates cognitively intact (a person is able to think clearly, remember things well, and make sound decisions, essentially having normal brain function with no significant problems with thinking, learning, or reasoning abilities), 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 10 was severely impaired. During a review of Resident 10's Smoking Order (SO), dated 2/26/24, the SO indicated . Order date: 2/26/24 at 9 a.m., Communication Method: Phone . Order Summary: Ok for resident to smoke nicotine products . at designated smoking area at designated smoking times . Confirmed by Licensed Vocational Nurse [LVN] 2 . During an observation on 2/19/25 at 11 a.m., in the designated smoking area on the back patio of the facility with Resident 10 and Activities Personnel (AP) 1, Resident 10 smoked three cigarettes and dropped ashes on his shirt and between his legs onto his wheelchair. Resident 10 was not wearing a smoking apron. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 11:06 a.m., with LVN 1, LVN 1 stated Resident 10 should have had a smoking apron (worn over the front of the body to prevent burns to clothing and keep hot ashes from burning the skin) on when he was smoking to prevent being burned. LVN 1 stated he needed the apron because he was not mentally alert and had poor safety awareness. LVN 1 stated due to Resident 10's BIMS, he could not keep himself safe. LVN 1 stated it was not safe for Resident 10 to be smoking if the ashes fell on him. During an interview on 2/21/25 at 9:59 a.m., with LVN 2 (she was also Director of Staff Development and Infection Preventionist), LVN 2 stated the expectation for Resident 10 was to be able to smoke safely. LVN 2 stated the expectation was not met and Resident 10 was at risk for burns and injury. LVN 2 stated the policy and procedure (P&P) Smoking Policy- Residents was not followed. During an interview on 2/21/25 at 3:13 p.m., with the Director of Nursing (DON), the DON stated Resident 10 should not have had ashes falling on him while smoking. The DON stated this was a safety concern. The DON stated the ashes could have still been hot and could have caused a skin injury. The DON stated the P&P Smoking Policy- Residents was not followed. During an interview on 2/24/25 at 10:51 a.m., with AP 1, AP 1 stated she was out there with Resident 10 and had not had any training in terms of facility smoking procedures. AP 1 stated her job was to take any resident out that was allowed to smoke and make sure they do not get burned. AP 1 stated she forgot to give Resident 10 a smoking apron that day. AP 1 stated Resident 10 dropping ashes on himself was a safety issue. AP 1 stated Resident 10 could catch fire and that was why the smoking apron should have been worn. During a review of the facility's P&P titled Smoking Policy- Residents, dated 5/2023, the P&P indicated, . this facility shall establish and maintain safe resident smoking practices . residents must be offered the non-combustible apron prior to smoking .

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on observations, interview, and record review, the facility failed to provide the correct diet for one of 12 sampled residents (Resident 2) during lunch tray assembly when Resident 2 was on a fortified diet (an enrichment of food to increase calories [a unit of energy] and protein [essential to building and repairing body tissues, muscles, and bones] to sustain or gain weight) and dietary staff did not follow the diet order on 2/18/25 to provide Resident 2 with a Magic Cup frozen dessert (ice cream with added calories and protein for those experiencing involuntary weight loss). This failure had the potential to result in Resident 2 to not receive the adequate nutritional requirements to sustain or gain weight. Findings: 1. During a record review of Resident 2's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/24/25, the AR indicated, Resident 2 was admitted to the facility on [DATE], with diagnosis that included Hospice Care (palliative care for terminally ill residents), Confusional Arousals (a sleep disorder causing confusion and disorientation that occur during or shortly after waking from sleep), Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Hypertension (high blood pressure), Muscle Weakness, Repeated Falls, and Atrial Fibrillation (an irregular and often very rapid heart rate). During a record review of Resident 2's Physician Order Summary (POS), dated 2/24/25, the POS indicated, Resident 2 was on a Fortified Diet Mechanical Soft Texture (food that is chopped, grounded, or pureed to accommodate with swallowing), Thin Liquids Consistency. During a record review of the facility's [name of company] Weekly Menu February 2025 - Week 2 Fortified Lunch, dated 2/10/25-2/14/25, the guideline indicated, 4 ounce (oz- unit of measurement) Magic Cup. During a review of Resident 2's Minimum Data Set (MDS, an assessment tool which indicates physical, medical, and cognitive abilities), dated 2/18/25, the MDS indicated Resident 2's Brief Interview for Mental Status (BIMS) score was 3 out of 15 (0-7 indicated severe cognitive impairment [memory loss, poor decision making-skills], 8-12 moderate cognitive impairment, 13-15 cognitively intact). During a concurrent observation and interview on 2/18/25 at 12:10 p.m., with Resident 2 in the dining/activity room, Resident 2 was observed sitting in a chair, with an overbed table and meal tray for lunch. Resident 2's lunch tray consisted of one flour tortilla with ground meat and shredded cheese, pinto beans with shredded cheese, 8 ounce (equivalent to one cup) of 2 percent milk, a cup of coffee, a cup of green salad, and a slice of cake. Resident 2 was unable to give a meaningful response when asked about the palatability of her food. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/19/25 at 1:53 p.m., with Dietary [NAME] (CK) 1, Resident 2's lunch tray photo, dated 2/18/25 was reviewed. CK 1 stated Resident 2's lunch tray was not served correctly, and the Magic Cup was missing. CK 1 stated Resident 2's Magic Cup was added to her meal tray to ensure resident received the needed extra calories for weight gain. CK 1 stated Resident 2 could potentially lose weight from not having appropriate diet served each meal. During a concurrent interview and record review on 2/19/25 at 3:13 p.m., with the Dietary Supervisor (DS), Resident 2's lunch tray photo, dated 2/18/25, was reviewed. The DS stated Resident 2's lunch tray was not prepared correctly, and the magic cup was missing. The DS stated she expected the dietary staff to check the diet order and meal tray during meal preparation and it was not done. The DS stated Resident 2 could possibly experience weight loss from not having proper diet served each meal. During a concurrent interview and record review on 2/20/25 at 9:42 a.m., with the Registered Dietician (RD), Resident 2's POS, undated, was reviewed. The RD stated Resident 2 had diet recommendations to be on a fortified diet while on Hospice. The RD stated dietary staff were expected to follow the recommended dietary order and it was not done. The RD stated Resident 2 could potentially lose weight from not having appropriate diet served each meal. During a review of the facility's Job Description titled, Dietary Cook/Worker, undated, the Job Description indicated, . Essential Job Functions: . Understand and follow color coding and abbreviations of tray cards and therapeutic (specialized meal plan designed to treat or manage specific health conditions) menus . Be familiar with policies and procedures of the dietary department . During a review of the facility's policy and procedure (P&P) titled, Diet Orders and Menu Distribution, dated 11/20, the P&P indicated, Policy: To device a systematic procedure to process diet orders and distribute menus . A. All information regarding diet orders is written on the diet communication sheet by the nursing staff . There must be a written diet order in the patient's medical record before food may be served to the patient .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 44899 Based on observation, interview, and record review, the facility failed to store and distribute food in accordance with professional standards for food service safety when the sink faucet was covered with a black and brown substance. This failure placed residents who consumed food prepared in the facility kitchen at risk for foodborne illness (a disease caused by consuming contaminated food or drink). Findings: During a concurrent observation and interview on 2/18/25 at 9:15 a.m., with the Dietary Supervisor (DS), in the kitchen, the sink faucet located near the dish washing machine was observed with a black and brown substance. The DS stated the base of the sink faucet was not clean and the sink faucet should be cleaned daily. During an interview on 2/19/25 at 1:53 p.m., with [NAME] 1, [NAME] 1 stated they were supposed to clean the sink faucet daily and it was not done. [NAME] 1 stated the 27 facility residents received their meals daily from the kitchen and could potentially get ill because of cross contamination (spread of harmful bacteria from one place or object to another). During an interview on 2/19/25 at 3:13 p.m., with the DS, the DS stated dietary staff were tasked to clean the sink faucet daily and it was not done. The DS stated facility residents were at risk for foodborne illness when food was not prepared in a clean environment. The DS stated, Cross contamination could cause illness to our residents. During a review of the facility's document titled, Job Description: Dietary Cook/Worker, undated, the document indicated, . Use all utensils and equipment in a safe and sanitary manner . During a review of the facility's policy and procedure (P&P) titled, Sanitation in Preparation and Serving, dated 7/11, the P&P indicated, . Strict adherence to the following rules will eliminate the hazard of food poisoning while food is being prepared and served . All equipment should be cleaned and sanitized before use .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 44899 Based on interview and record review, the facility failed to follow its Hospice (care that focuses on the quality of life for people who are experiencing an advanced, life-limiting illness) policy and procedures (P&P) for one of four sampled residents (Resident 10) when: 1. The pharmacy recommendation for Resident 10 to obtain Serum (blood test) B-12 (a vitamin essential for maintaining healthy red blood cells, nerves, and brain function), Creatinine Level (a blood test to check for the kidney's function), Liver Function (a blood test to check for liver's function) and BMP (Basic Metabolic Panel-measures various substances in the blood, including blood sugar and bone health) was not communicated to the Hospice provider. 2. The Hospice order for Resident 10 to discontinue all laboratory tests on 1/21/25 was not carried out and implemented. These failures had the potential to place Resident 10 at risk for receiving treatments or procedures against his wishes. Findings: 1. During a review of Resident 10's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 2/21/25, the AR indicated, Resident 10 was admitted from an acute care hospital on 1/19/24 to the facility, with diagnoses that included Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Hypertension (high blood pressure), Cerebral Infarction (stroke-bleeding inside the brain), and Type 2 Diabetes Mellitus (high blood sugar). During a review of Resident 10's Physician Order Summary Report (POS), dated 2/21/25, the POS indicated, . admitted under the care of [Name of Hospice Agency] . Order Date 1/19/24 . Do Not Resuscitate [DNR-a legal document that instructs medical professionals not to perform resuscitation (artificial breathing) if a patient's breathing or heart stops] . During a concurrent interview and record review on 2/21/25 at 9:22 a.m., with the Director of Nursing (DON), Resident 10's Progress Note (PN), undated, and Pharmacy Monthly Medication Review Recommendation (MRR), dated 1/28/25 were reviewed. The MRR indicated, . patient is receiving [generic name](medication to control blood sugar level) 500 [milligram (mg) - unit of measurement] daily, which may deplete (reduce) vitamin B-12 and has the potential to cause lactic acidosis (excess amount of lactic acid in the blood, causing nausea, vomiting, exhaustion, fatigue and body aches). Please consider ordering a serum B-12 level as baseline and annually to monitor therapy, as well as serum creatinine level, liver function and BMP every 6 months . The DON stated she does not have any record the pharmacy recommendation was forwarded to the Hospice agency for review. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview and record review, on 2/21/25 at 1:54 p.m., with the Hospice Director of Patient Care Services (HDPCS), Resident 10's Hospice Clinical Record (HCR), dated 2/21/25 was reviewed. The DPCS stated Resident 10 was under Hospice care since 1/19/24 and they worked closely with the facility staff to meet Resident 10's physical, emotional, and spiritual needs. The DPCS stated they did not have any record of pharmacy recommendations to obtain various laboratory tests, otherwise they would act on it. During a concurrent interview and record review, on 2/21/25 at 5:05 p.m., with the DON, the facility's Hospice Program Policy and Procedure (P&P), dated 7/17 was reviewed. The P&P indicated, . 9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness (a condition with no treatment) and related conditions . c. Providing medical direction, nursing, and clinical management of the terminal illness . 12. Our facility has designated [blank space] to coordinate care provided to the resident by our facility staff and the hospice staff . The DON stated she does not have any record or proof that the facility staff communicated the pharmacy recommendation to the hospice agency. The DON stated, If it's not documented, it didn't happen. During a concurrent interview and record review, on 2/24/25 at 11:29 a.m., with the Director of Staff Development (DSD, also the Infection Preventionist [IP] and Licensed Vocational Nurse [LVN] 2), Resident 10's Progress Note (PN), dated 2/24/25 and Physician Order Summary (POS), dated 2/24/25 were reviewed. The DSD stated she does not have any record the pharmacy recommendation was forwarded to the Hospice agency for review. The DSD stated Resident 10 could potentially receive treatment or procedures against his wishes. During a review of the facility's P&P titled, Hospice Program, dated 7/17, the P&P indicated, . Hospice services are available to residents at the end of life . 12. Our facility has designated [blank space] to coordinate care provided to the resident by our facility staff and the hospice staff .e. Ensuring that our facility staff provides orientation on the P&P of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents . 13. Coordinated care plans for residents receiving hospice services . in order to maintain the resident's highest practicable physical, mental and psychosocial well-being . 2. During a concurrent interview and record review, on 2/21/25 at 1:57 p.m., with the Hospice Director of Patient Care Services (HDPCS), Resident 10's Hospice Physician Order (HPO), dated 1/21/25 was reviewed. The HPO indicated, . [discontinue] all routine labs [laboratory tests] . The HDPCS stated the expectation was for the facility staff to follow the hospice recommendation. During a concurrent interview and record review, on 2/21/25 at 5:05 p.m., with the DON, Resident 10's POS, undated 2/21/25, and Resident 10's HPO, dated 1/21/25 were reviewed. The DON stated she does not have any record or proof the facility staff received Resident 10's physician order to discontinue all laboratory tests from the hospice agency. The DON stated, If it's not documented, it didn't happen. During a concurrent interview and record review, on 2/24/25 at 11:31 a.m., with the DSD (also the IP and LVN 2), Resident 10's PN, dated 2/24/25, and Resident 10's POS, dated 2/24/25, were reviewed. The DSD stated she does not have any record the facility staff received a physician order to discontinue Resident 10's laboratory tests from the hospice agency. The DSD stated Resident 10's could potentially received treatment or procedures against his wishes. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Hospice Program, dated 7/17, the P&P indicated, . Hospice services are available to residents at the end of life . 12. Our facility has designated [blank space] to coordinate care provided to the resident by our facility staff and the hospice staff .e. Ensuring that our facility staff provides orientation on the P&P of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents . 13. Coordinated care plans for residents receiving hospice services . in order to maintain the resident's highest practicable physical, mental and psychosocial well-being .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview, and record review the facility failed to ensure effective infection prevention and control practices were implemented for nine of 14 sampled residents (Resident 21, 11, 5, 16, 15, 78, 8, 14, and 20) when: 1. Licensed Vocational Nurse (LVN) 1 did not perform hand hygiene when entering and exiting the rooms for Resident 21, 11, 5, 16, 15, 78, 8, 14, and 20. 2. LVN 1 did not remove gloves after providing patient care for Resident 16, 78, 14, and 20 and exited the room and walked down the hallway back to his medication cart (a mobile cart for storing and delivering medications). 3. LVN 1 did not take his medication cart located in Nursing Station 1 instead of bringing it to each room while administering medications and patient care for Resident 21, 11, 5, 16, 15, 78, 8, 14, and 20. These failures had the potential to result in the spread of infections (when germs enter the body and cause illness) and cross-contamination (transfer of germs or substances from one surface to another), compromising the health and safety of the residents. Findings: 1. During a review of Resident 21's Admission Record (AR), dated 2/29/25, the AR indicated Resident 21 was admitted on [DATE] with a diagnosis(es) of vascular dementia (memory loss caused by poor blood flow to the brain), cerebral edema (swelling in the brain), Type 2 diabetes mellitus (a disease that causes high levels of sugar in the blood) and essential hypertension (high blood pressure with no clear cause). During a review of Resident 11's AR, dated 2/19/25, the AR indicated, Resident 11 was admitted on [DATE] with a diagnosis(es) of diabetes mellitus, essential hypertension, dehydration (when the body loses too much water), and constipation (hard stools) During a review of Resident 5's AR, dated 2/19/25, the AR indicated, Resident 5 was admitted on [DATE] with a diagnosis(es) of muscle weakness, pain unspecified (pain without clear cause or location), difficulty walking, and pain in the right and left knee. During a review of Resident 16's AR, dated 2/19/25, the AR indicated, Resident 16 was admitted on [DATE] with a diagnosis(es) of Type 2 diabetes mellitus and gastro-esophageal reflux disease without esophagitis (a condition where stomach acid leaks into the throat without causing inflammation). During a review of Resident 15's AR, dated 2/19/25, the AR indicated, Resident 15 was admitted on [DATE] with a diagnosis(es) of unspecified atrial fibrillation (an irregular and fast heart beat) essential hypertension, hyperlipidemia (high levels of fat in the blood), hypothyroidism (a condition when the thyroid [a small gland in the neck] makes too little hormones [a chemical that help control body functions]), anemia (not enough red blood cells to carry oxygen), and muscle weakness. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 78's AR, dated 2/19/25, the AR indicated, Resident 78 was admitted on [DATE] with a diagnosis(es) of essential hypertension, chest pain, and presence of cardiac pacemaker (a device that helps regulate a heart's rhythm). During a review of Resident 8's AR, dated 2/19/25, the AR indicated, Resident 8 was admitted on [DATE] with a diagnosis(es) of chronic obstructive pulmonary disease (a lung disease that makes it hard to breath), allergic contact dermatitis (a skin rash caused by an allergic reaction to something that touches the skin), unspecified dementia (a decline in memory and thinking skills without a clear cause) and essential hypertension. During a review of Resident 14's AR, dated 2/19/25, the AR indicated, Resident 14 was admitted on [DATE] with a diagnosis(es) of type 2 diabetes mellitus, klebsiella pneumoniae (a bacteria [germ] that can cause lung infections and other diseases), and urinary tract infection (an infection in the urinary tract). During a review of Resident 20's AR, dated 2/19/25, the AR indicated, Resident 20 was admitted on [DATE] with a diagnosis(es) of type 2 diabetes mellitus. During an observation on 2/19/25 at 8:31 a.m. in Resident 21's room, LVN 1 took Resident 21's blood pressure (the force of blood against the veins [blood vessels that carry blood to the heart] and arteries [blood vessels that carry blood away from the heart] as the heart pumps) using a blood pressure machine (a machine used to measure blood pressure). LVN 1 exited the room and did not perform hand hygiene (cleaning hands to remove germs and prevent infections). During an observation on 02/19/25 at 8:43 a.m., LVN 1 did not perform hand hygiene when he entered Resident 11's room. LVN 1 administered loperamide (a medication to control symptoms of diarrhea) 2mg (milligrams-a unit of measure) to Resident 11 and did not perform hand hygiene before exiting Resident 11's room. During an observation on 2/19/25 at 8:49 a.m., LVN 1 did not perform hand hygiene when he entered Resident 5's room. LVN 1 administered a lidocaine patch (a medicated patch that numbs pain in a specific area) 5% (percent- a unit of measure) to Resident 5's right knee and did not perform hand hygiene when he exited Resident 5's room. During an observation on 2/19/25 at 8:53 a.m., LVN 1 administered lorazepam (a medication used to control anxiety [feeling of worry, fear or nervousness]) 0.5ml (milliliter-a unit of measure) to Resident 16. LVN 1 did not perform hand hygiene when he exited Resident 16's room. During an observation on 2/19/25 at 11:08 a.m. in Resident 15's room, LVN 1 did not perform hand hygiene after he administered medications to Resident 15 and exited the Resident 15's room. During an observation on 2/19/25 at 11:11 a.m., LVN 1 went inside Resident 78's room to check his blood pressure. LVN 1 did not do hand hygiene when he entered Resident 78's room. LVN 1 had a gloved hand when he exited Resident 78's room and did not perform hand hygiene when he exited. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/19/25 at 11:16 a.m. in Resident 8's room, LVN 1 wore gloves and administered Resident 8's polyethylene glycol (a medication used to relieve dry, irritated eyes) 400 0.4%, propylene glycol 0.3% . LVN 1 removed his gloves and did not perform hand hygiene when he exited the room. During an observation on 2/19/25 at 11:24 a.m. in Resident 14, LVN 1 checked Resident 14's blood sugar using a glucometer (a devise that measures blood sugar). LVN 1 walked out of the room and did not perform hand hygiene. During an observation on 2/19/25 at 11:28 a.m. in Resident 14's room, LVN 1 administered insulin on Resident 14's lower left abdomen. LVN 1 removed his gloves after he administered the insulin (a medication that controls blood sugar) and did not perform hand hygiene. During an observation on 2/19/25 11:41 a.m. in Resident 20's room, LVN 1 entered Resident 20's room and did not perform hand hygiene. LVN 1 donned (put on) gloves and administered insulin on Resident 20's lower right abdomen. LVN 1 removed his gloves and did not perform hand hygiene and went back to the medication cart in Nursing Station 1. During an interview on 2/19/25 at 12:08 p.m. with LVN 1, LVN 1 stated, he should have performed hand hygiene before and after leaving a resident's room and before and after performing patient care. LVN 1 stated, after performing patient care for three to four residents, he should have washed his hands with soap and water. LVN 1 stated, it was important to perform hand hygiene to prevent cross-contamination from one patient to another and prevent the spread of infections. During an interview on 2/19/25 at 2:01 p.m. with the Infection Preventionist (IP), the IP stated, it was her expectation to perform hand hygiene whenever a staff entered and exited a resident's room. The IP stated, hand hygiene should also have been performed before and after performing patient care such as checking blood sugars, checking blood pressures, and administering medications. The IP stated, it was important to perform hand hygiene to prevent the spread of infections and prevent cross-contaminations. During an interview on 2/21/25 at 11:34 a.m. with the Director of Nursing (DON), the DON stated, staff had to perform hand hygiene before and after entering a resident's room and before and after providing patient care. The DON stated, failure to adhere to hand hygiene protocols could have led to cross-contamination and the spread of infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 8/2019, the P&P indicated, .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .hand hygiene products and supplies (sinks, soaps, towels, alcohol-based hand rubs, etc.) shall be readily accessible and convenient for staff to encourage compliance with hand hygiene policies . use some alcohol based hand rope containing at least 62% alcohol; Or, alternatively, soap (antimicrobial [a substance that kills or stops germs]) . before and after direct contact with residents . Before preparing or handling medications . before performing any non-surgical invasive (enot breaking the skin or entering the body) procedures . Before and after handling an invasive device (e.g. Urinary catheters, IV access sites) . before donning sterile gloves . after contact with the resident's intact skin . after contact with blood or bodily fluids . after handling used dressings, contaminated (dirty or exposed to germs) equipment . after contact with objects (e.g., medical equipment) . after removing gloves . hand hygiene is the final step after removing and disposing of personal protective equipment . the use of gloves does not replace hand washing/hand hygiene . 2. During an observation 2/19/25 at 8:53 a.m., LVN 1 wore a glove when he administered Resident 16's lorazepam. LVN 1 left the room while wearing the same glove back to the medication cart in Nursing Station 1. During an observation on 2/19/25 at 11:11 a.m., LVN 1 wore gloves when he took Resident 78's blood pressure. LVN 1 left the room while wearing the same glove back to the medication cart in Nursing Station 1. During an observation on 2/19/25 at 11:24 a.m., in Resident 14's room, LVN 1 wore gloves while checking Resident 14's blood sugar using a glucometer. LVN 1 did not remove his gloves after checking Resident 14's blood sugar and left the room. LVN 1 walked from Resident 14's room to the medication cart in Nursing Station 1 while still wearing his gloves. During an observation on 2/19/25 at 11:35 a.m., LVN 1 wore gloves while checking Resident 20's blood sugar using a glucometer. LVN 1 did not remove his gloves after checking Resident 20's blood sugar and left the room. LVN 1 walked from Resident 20's room to the medication cart in Nursing Station 1 while still wearing his gloves. During an interview on 2/19/25 at 12:08 p.m. with LVN 1, LVN 1 stated he should not have worn gloves in the hallway after finishing patient care. LVN 1 stated, there was a risk of cross-contamination when walking in the hallway. LVN 1 stated, he could have been distracted and touched something in the hallway that could have harbored germs and potentially spread them to other residents. During an interview on 2/19/25 at 2:01 p.m. with the IP, the IP stated, gloves should not have been worn while walking in the hallway. The IP stated, there was potential for cross-contamination when soiled gloves were worn in the hallway and could have potentially caused infections to spread. The IP stated, gloves should be removed before exiting a resident's room. During an interview on 2/2/25 at 11:34 a.m. with the DON, the DON stated, nurses should not walk down the hallway with gloved hands after providing patient care. The DON stated, walking with soiled gloves could potentially cause cross-contamination and spread infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated 8/2019, the P&P indicated, . The use of gloves does not replace hand/hygiene .integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections .applying and removing gloves .perform hand hygiene before applying non-sterile gloves . During a review of the professional reference (PR) titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings found on www.cdc.gov/infection-control/hcp/core-practices/index.html, dated 4/12/24, the PR indicated, .remove and discard PPE, other than respirators, upon completing a task before leaving the patient's room or care area .remove and discard disposable gloves upon completion of a task or when soiled during the process of care . 3. During a concurrent observation and interview on 2/19/25 at 8:40 a.m. with LVN 1 in Resident 21's room, LVN 1 administered Resident 21's morning medications. LVN 1 prepared Resident 21's morning medications on the medication cart located at Nursing Station 1. LVN 1 walked to Resident 21's room and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 12 feet away from Resident 21's room. During a concurrent observation and interview on 2/19/25 at 8:43 a.m. with LVN 1, LVN 1 prepared Resident 11's loperamide 2mg on the medication cart located at Nursing Station 1. LVN 1 walked to Resident 11's room and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 17 feet away from Resident 11's room. During a concurrent observation and interview on 2/19/25 at 8:49 a.m. with LVN 1, LVN 1 had opened a lidocaine patch on the medication cart located at Nursing Station 1 for Resident 5. LVN 1 walked to Resident 5's room and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 30 feet away from Resident 5's room. During a concurrent observation and interview on 2/19/25 at 8:53 a.m. with LVN 1, LVN 1 prepared Resident 16's lorazepam on the medication cart located at Nursing Station 1. LVN 1 walked to the activities room to administer Resident 16's lorazepam and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 75 feet away from the activities room. During a concurrent observation and interview on 2/19/25 at 11:08 a.m. with LVN 1, LVN 1 prepared Resident 15's medications on the medication cart located at Nursing Station 1. LVN 1 walked to the activities room to administer Resident 15's medication and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 75 feet away from the activities room. During a concurrent observation and interview on 2/19/25 at 11:11 a.m. with LVN 1, LVN 1 prepared Resident 78's medication on the medication cart located at Nursing Station 1. LVN 1 walked to Resident 78's room and did not take the medication cart with him. LVN 1 stated, the medication cart was approximately 120 feet way from Resident 78's room. During a concurrent observation and interview on 2/19/25 at 11:16 a.m. with LVN 1, LVN 1 walked to Resident 8's room and administered his eye drops. LVN 1 did not bring the medication cart with him when we walked to Resident 8's room. LVN 1 stated, Resident 8's room was approximately 120 feet away from the medication cart located by Nursing Station 1. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555530	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chowchilla Memorial Healthcare District	1104 Ventura Ave. Chowchilla, CA 93610

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/19/25 at 11:16 a.m. with LVN 1, LVN 1 walked to Resident 8's room and administered his eye drops and did not bring the medication cart with him. LVN 1 stated, Resident 8's room was approximately 120 feet away from the medication cart located by Nursing Station 1. During a concurrent observation and interview on 2/19/25 at 11:19 a.m. with LVN 1, LVN 1 prepared Resident 14's medication on the medication cart located at Nursing Station 1. LVN 1 walked to Resident 14's room and did not bring the medication cart with him. LVN 1 administered Resident 14's breathing treatment (a therapy that uses inhaled medications to improve breathing) and checked her blood sugar with a glucometer. LVN 1 walked back to the medication cart after he finished and cleaned the glucometer at the medication cart. LVN 1 stated, Resident 14's room was approximately 17 feet away from the medication cart located by Nursing Station 1. During an observation on 2/19/25 at 11:26 a.m., LVN 1 walked back to Resident 14's room and did not take the medication cart. LVN 1 used an insulin syringe (small needle used to inject insulin) and administered Resident 14's insulin. LVN 1 left the room and walked back to the medication cart by Nursing Station 1. During a concurrent observation and interview on 2/19/25 at 11:35 a.m., LVN 1 walked to Resident 20's room to check her blood sugar with a glucometer and did not bring the medication cart with him. LVN 1 walked back to the medication cart located at Nursing Station 1 to clean the glucometer and prepare Resident 20's insulin. LVN 1 stated, Resident 20's room was approximately 17 feet away from the medication cart located by Nursing Station 1. During an observation on 2/19/25 at 11:41 a.m., LVN 1 held an insulin syringe and walked back to Resident 20's room. LVN 1 administered the insulin to Resident 20 and walked back to the medication cart while holding the insulin syringe. During an interview on 2/19/25 at 12:08 p.m., LVN 1 stated, he should have taken the medication cart with him each time he administered medications to a resident. LVN 1 stated, keeping the medication cart nearby was important to ensure all supplies were within reach and to avoid walking across the hallway, which helped prevent the risk for cross-contamination of medications to be administered to residents. During an interview on 2/19/25 at 2:01 p.m. with the IP, the IP stated nurses should have taken the medication cart with them while passing medications. The IP stated, having the medication cart nearby allowed the nurse to have immediate access to supplies or medications. The IP stated, walking back and forth between room and a distant medication cart posed a potential risk for cross-contamination. During an interview on 2/21/25 at 11:34 a.m. with the DON, the DON stated, nurses had to take the medication cart with them wherever they provided patient care. The DON stated, keeping the medication cart nearby allowed nurses to have immediate access to supplies and medications. The DON stated, walking back and forth between resident's room and a distant medication cart posed a potential risk for cross-contamination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555530	A. Building B. Wing	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chowchilla Memorial Healthcare District	1104 Ventura Ave. Chowchilla, CA 93610

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the professional reference (PR) titled, CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, found on www.cdc.gov/infection-control/hcp/core-practices/index.html , dated 4/12/24, the PR indicated, .Injection and Medication Safety .Prepare medications in a designated clean medication preparation area that is separated from potential sources of contamination . 51620