STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555663	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lindsay Gardens Nursing & Rehabilitation	1011 W. Tulare Road Lindsay, CA 93247

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure when physician orders were not entered correctly in the electronic medical record (EMR) and wound treatments were not being documented on the Treatment Administration Record (TAR) for one of three sampled residents (Resident 1). This failure resulted in the medical record being inaccurate. Findings:During a review of the Order Review Report (ORR) dated 4/1/26-4/30/26, the ORR indicated, Tx (treatment) coccyx (tailbone) cleanse w/dws (dermal wound spray-used to clean wounds), pat dry, apply Medihoney (medication used to treat wounds) and foam dressing q (every) shift.order date.4/23/26.Tx (Treatment) bilateral toes and bilateral ankles: cleanse w/ (with) dws, pat dry, and apply betadine (topical medication used to prevent infections) qshift.Order date.4/23/26.During a review of Resident 1's TAR, dated [DATE], the TAR indicated there were no documented treatments to Resident 1's coccyx, bilateral toes and bilateral ankles.During a review of Resident 1's Care Plan (CP) dated 4/23/26, the CP indicated, Resident has a pressure ulcer to (sacrococcyx) and is at risk for further breakdown and/or slow, delayed healing related to advanced aging process.Interventions/Tasks.Administer treatment as ordered.During a review of Resident 1's CP dated 4/23/26, the CP indicated, Skin: resident has a venous stasis ulcer to (bilateral toes and ankles) and is at risk for further breakdown and/or slow, delayed healing related to advanced aging process.Interventions/Tasks.Administer treatment as ordered.During a concurrent interview and record review, on 5/19/26 at 11:58 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 1's clinical record was reviewed. LVN 1 was unable to find documentation of the wound treatments being documented when administered. LVN 1 stated when the treatments were administered they should have been documented on the TAR.During a concurrent interview and record review, on 5/19/26 at 12:07 p.m. with Director of Nursing (DON), Resident 1's clinical record was reviewed. DON was unable to provide documentation of the wound treatments when administered. DON stated the physician orders were entered incorrectly and were not indicated to appear on the TAR when administered and they should have been. DON stated when the treatments were administered, they should have been documented on the TAR.During an interview on 5/19/26 at 12:34 p.m. with Assistant Director of Nursing (ADON), ADON stated she was unable to provide evidence of Resident 1's treatments being documented after administration.During an interview on 5/20/26 at 4:40 p.m. with LVN 2, LVN 2 stated she was the nurse that was on duty when Resident 1 was admitted to the facility on [DATE]. LVN 2 stated Resident 1 was admitted with wounds. LVN 2 stated when she administered wound treatments they should have been documented on the TAR.During an interview on 5/29/26 at 8:52 a.m. with LVN 3, LVN 3 stated when Resident 1 was admitted to the facility on [DATE], Resident 1 was admitted with several wounds. LVN 3 stated he was the one that entered the treatment orders into the EMR when Resident 1 was admitted but the orders were entered incorrectly and they did not appear on the TAR for administration. LVN 3 stated the wound treatments should have been documented on the TAR when he administered them.During a review of the facility policy and procedure (P&P) titled, Wound Care (WC) dated 4/2026, the P&P indicated, the purpose of this (continued on next page)

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

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

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	procedure is to provide guidelines for the care of the wounds to promote healing.Documentation.The following information should be recorded in the resident's medical record.the type of wound care given.the date and time the wound care was given.the name and title of the individual performing the wound care.