STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555758	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Bethany Skilled Nursing	1441 Berkeley Dr Los Banos, CA 93635

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41608 Based on observation, interview and record review, the facility failed to ensure two of 12 sampled residents (Resident 128 and 19) were treated with dignity and respect when: 1. Resident 19 was assisted with lunch by Certified Nursing Assistant (CNA) 1, CNA 1 did not engage in conversation and did not inform the resident when she was providing beverages, spoons with food or wiping her face. This failure resulted in Resident 19 not being provided a respectful and dignified dining experience which could further enhance resident's quality of life. 2. Resident 128's urinary catheter (a flexible tube inserted through a narrow body opening into the bladder and used for draining urine) bag was left uncovered. Findings: 1. During an observation on 6/19/24 at 12:20 p.m. in the facilities dining room, CNA 1 was seated next to Resident 19 assisting her with her lunch. Resident 19 was nonverbal; her eyes were closed, fists clenched, and she was unable to feed herself. Resident 19 had a white cloth fastened around her neck covering the front of her chest area. CNA 1 was placing spoons of food and up to Resident 19's mouth, when Resident 19's lips would part CNA 1 would put the spoon in Resident 19's mouth. Resident 19 would grimace after each spoon full of food. CNA 1 would place the beverage up to Resident 19's mouth and when her lips would part CNA 1 would pour the beverage in her mouth without informing her it was liquid. CNA 1 would take the cloth around Resident 19's neck and wipe her face without warning her. CNA 1 was calling out to other residents in the dining room, engaging in conversation with Licensed Vocational Nurse (LVN) 1 but did not engage in conversation with Resident 19, while assisting her. During an interview on 6/19/24 at 12:25 p.m. with CNA 1, CNA 1 stated she would not want to be fed the way she was feeding Resident 19. CNA 1 stated Resident 19 should have been her only focus, she should have been informing her what she was attempting to put in her mouth and identify between beverage or food. CNA 1 stated she should have warned her prior to wiping her face as to not startle Resident 19. CNA 1 stated she was not feeding Resident in a dignified manner, and she was not following the facility policy or meeting the facilities expectations. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/19/24 at 12:29 p.m. with LVN 1, LVN 1 stated she was present in the dining room at the time of the incident. LVN 1 stated CNA 1 was not assisting Resident 19 per the policy or facility expectations. LVN 1 stated CNA 1 should have been focused on Resident 19 and not engaged in conversations with other residents and staff including herself. LVN 1 stated she would not like to be fed the way CNA 1 was feeding Resident 19. LVN 1 stated she would feel embarrassed or even scared not knowing what was happening. During an interview on 6/19/24 at 10:11 a.m., with the Director of Nurses (DON), the DON stated CNA 1 did not treat Resident 19 with dignity or respect when she did not engage with the resident and did not inform her what she was putting in her mouth. The facility expects staff to always follow policy and procedure, all residents are to be always treated with respect and dignity. During a review of Resident 19's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/20/24, the AR indicated, Resident 19 was admitted from an assisted living facility on 9/15/22 with diagnosis of, Dementia (general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Anemia (lack of healthy red blood cells), hypothyroidism (happens when the thyroid gland doesn't make enough thyroid hormone), and Vitamin D deficiency. During a review of Resident 19's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/31/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 19 had severe cognitive impairment During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2/21, the P&P indicated . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 5. When assisting with care, residents are supported n exercising their rights . e. provided with a dignified dining experience. 44899 2. During an observation and interview on 6/18/24, at 10:28 a.m., with Resident 128, inside Resident 128's room, Resident 128's urinary catheter bag containing urine was hung to her wheelchair uncovered. Resident 128 stated she was not aware that it should be covered at all times to preserve her dignity. During a concurrent observation and interview on 6/18/24, at 11:00 a.m., with Licensed Vocational Nurse (LVN) 1, in Resident 128's room, LVN 1 validated the urinary catheter bag has urine and was not covered. LVN 1 stated Resident 128's urinary catheter bag should have been placed in a dignity bag to ensure privacy. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/20/24, at 9:48 a.m., with the Director of Nursing (DON), the DON stated the urinary catheter bag should have been covered to ensure resident dignity was maintained. The DON stated the facility failed to follow the facility's policy on maintaining Resident 128's dignity at all times. During a review of Resident 128's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/20/24, the AR indicated, Resident 128 was admitted from an acute care hospital on 6/6/24 to the facility, whose diagnoses included Malignant Neoplasm of Bladder (bladder cancer), Hypertension (high blood pressure), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Constipation. During a review of Resident 128's Nursing Careplan (CP), dated 6/8/24 was reviewed. The CP indicated, . The resident has Left nephrostomy tube . Interventions . Foley bag should be placed below the bladder and placed in a privacy bag Resident prefers to use Foley bag to drain urine . During a review of the facility's policy and procedure (P&P) titled, Dignity, dated 2/21, the P&P indicated . Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem . 12. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: a. helping the resident to keep urinary catheter bags covered .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44899 Based on interview and record review, the facility failed to provide services which met professional standards of practice for 17 of 25 sampled residents (Residents 1, 2, 3, 4, 6, 10, 11, 12, 13, 14, 15, 17, 18, 19, 21, 127, and 128) when: 1. LVN 1 failed to explain the medication name and indication to Resident 1, 13, 18, 21, 127, and 128 during medication administration. This failure had the potential to place Residents 1, 13, 18, 21, 127, and 128 at risk of receiving the wrong medication and experience unnecessary side effects. 2.The facility failed to have a Licensed Nurse confirm the lunch meal tray matched residents' dietary orders for Residents 2, 3, 4, 6, 10, 11,12, 13, 14, 15, 17, 18, 19, and 21. This failure had the potential to place Residents 2, 3, 4, 6, 10, 11,12, 13, 14, 15, 17, 18, 19, and 21, at risk of receiving the wrong meal, choking, allergic reactions and weight loss. Findings: 1. During a medication pass observation on 6/18/24, at 11:01 a.m., inside Resident 127's room, LVN 1 administered Gabapentin (medication for nerve pain or inflammation) 100 MG (milligram, unit of measurement) capsule without explaining the medication and indication to Resident 127. During a review of Resident 127's Admission Record (AR, a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 6/21/24, the AR indicated, Resident 127 was admitted from an acute care hospital on 5/28/24 to the facility, whose diagnoses included Hypertension (high blood pressure), Anemia (low iron), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and Neuralgia (pain cause by damage nerves) and Neuritis (inflammation of nerves). During a review of Resident 127's Medication Administration Record (MAR), dated 6/24, the MAR indicated, . Gabapentin oral capsule 100 MG. Give 1 capsule by mouth three times a day for nerve pain . Order date 5/28/24 . During a medication pass observation on 6/18/24, at 11:05 a.m., inside Resident 1's room, LVN 1 administered Gabapentin 100 MG, 2 capsules (200 MG) without explaining the medication and indication to Resident 1. During a review of Resident 1's AR, dated 6/21/24, the AR indicated, Resident 1 was admitted from an acute care hospital on 5/8/24 to the facility, whose diagnoses included Hypertension, Anemia, Major Depressive Disorder, Neuropathy and Constipation. (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 review of Resident 1's MAR, dated 6/24, the MAR indicated, . Gabapentin oral capsule 100 MG. Give 2 capsules by mouth three times a day for Neuropathy . Order date 6/14/24 . During a medication pass observation on 6/18/24, at 11:21 a.m., inside Resident 18's room, LVN 1 administered Gabapentin 300 MG capsule without explaining the medication and indication to Resident 18. During a review of Resident 18's AR, dated 6/21/24, the AR indicated, Resident 18 was admitted from an acute care hospital on 5/4/24 to the facility, whose diagnoses included Cerebrovascular Disease (stroke), Atrial Fibrillation (Afib, is an irregular and often very rapid heart rate), Anemia, and Restless Leg Syndrome (RLS, a condition that causes a very strong urge to move the legs) and Major Depressive Disorder. During a review of Resident 18's MAR, dated 6/24, the MAR indicated, . Gabapentin oral capsule 300 MG. Give 1 capsule by mouth three times a day for pain . Order date 5/16/24 . During a medication pass observation on 6/18/24, at 11:26 a.m., inside Resident 13's room, LVN 1 administered Ferrous Sulfate (iron supplement) 325 MG tablet without explaining the medication and indication to Resident 13. During a review of Resident 13's AR, dated 6/21/24, the AR indicated, Resident 13 was admitted from an acute care hospital on 1/5/22 to the facility, whose diagnoses included Fracture of Right Femur (hip), Type 2 Diabetes Mellitus (abnormal or high blood sugar), Heart Failure (weakness in the heart where fluid accumulates in the lungs), Anemia, Hypertension and Major Depressive Disorder. During a review of Resident 13's MAR, dated 6/24, the MAR indicated, . Ferrous Sulfate 325 MG. Give 1 tablet by mouth three times a day for supplement . Order date 6/13/24 . During a medication pass observation on 6/18/24, at 11:26 a.m., outside the activity room, LVN 1 administered Ferrous Sulfate 325 MG, Sodium Bicarbonate (used to relieve heartburn) 650 MG, and NovoLog (insulin, used to lower blood sugar) without explaining the medications and indications to Resident 21. During a review of Resident 21's AR, dated 6/21/24, the AR indicated, Resident 21 was admitted from an acute care hospital on 6/16/23 to the facility, whose diagnoses included Type 2 Diabetes Mellitus, Huntington's Disease (cause the brain to decay overtime, causing uncontrolled body movements), Chronic Obstructive Pulmonary Disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow of the lungs), Dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities), Gastro-Esophageal Reflux Disease (GERD - condition where acid comes up from the stomach into the throat) and Anemia. (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 review of Resident 21's MAR, dated 6/24, the MAR indicated, . Ferrous Sulfate 325 MG. Give 1 tablet by mouth three times related to Iron Deficiency/Anemia . Order date 7/5/23 . Sodium Bicarbonate tablet 650 MG. Give 1 tablet by mouth three times a day related to Gastro-Esophageal Reflux Disease . Order date 6/16/23 . NovoLOG injection Solution . Inject 7 unit subcutaneously three times a day related to Type 2 Diabetes Mellitus . Order date 11/9/23 . During a medication pass observation on 6/18/24, at 11:40 a.m., inside Resident 128's room, LVN 1 administered Ferrous Sulfate (iron supplement) 325 MG tablet without explaining the medication and indication to Resident 128. During a review of Resident 128's AR, dated 6/21/24, the AR indicated, Resident 128 was admitted from an acute care hospital on 6/6/24 to the facility, whose diagnoses included Malignant Neoplasm of Bladder (bladder cancer), Hypertension, Major Depressive Disorder and Constipation. During a review of Resident 128's MAR, dated 6/24, the MAR indicated, . Ferrous Sulfate 325 MG. Give 1 tablet by mouth three times a day for supplement . Order date 6/13/24 . During an interview on 6/18/24, at 11:45 a.m., with LVN 1, LVN 1 stated she did not explain the medications and indications when she gave the medications to Residents 127, 1, 18, 13, 21, and 128. LVN 1 stated facility Residents had the right to know the medications they are receiving, and she failed to inform them (residents). During an interview on 6/20/24, at 10:02 a.m. with the Director of Nursing (DON), , the DON stated LVN 1 should explain the medications and their use prior to medication administration. The DON stated facility Residents have the right to know the medications they are receiving at all times. The DON stated LVN 1 failed to follow the facility's expectations and assigned responsibilities during medication pass. During a review of the facility's document titled, Job Description: Licensed Vocational Nurse, undated, the document indicated, . Duties and Responsibilities . The person holding this position is delegated the responsibility for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations and established company policies and procedures . 4. Prepare and administer medications and prescribed treatments . During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/19, the P&P indicated . Medications are administered in a safe and timely manner, and as prescribed . 5. Medication administration times are determined by resident need and benefit . c. honoring resident choices and preferences, consistent with his or her care plan . During a review of the facility's P&P titled, Resident Rights Guidelines for All Nursing Procedures, dated 10/10, the P&P indicated . For any procedure that involves direct resident care, follow these steps . d. Introduce yourself to the resident . g. Explain the procedure to the resident. Answer any questions he/she may have h. Ask permission to implement the procedure . 41608 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an observation on 6/19/24 at 12:10 p.m. in the facilities dining room, the lunch carts with the resident's meal trays arrived in the dining room. Residents were seated at designated tables waiting for their meal. The Certified Nursing Assistants (CNA), CNAs 1, 2, and 3 approached the meal cart and started taking meal trays to residents in the dining room. There were no licensed staff present to verify the meals the residents were receiving matched the ordered meal. During an observation on 6/19/24 at 12:15 p.m. CNA 4 was observed taking meal trays into rooms [ROOM NUMBERS] before the trays were checked by the Licensed Nurse, (LN). During an interview on 6/10/24 at 12:20 p.m. with CNA 4, CNA 4 stated he delivered the meal trays without having a LN checking them. CNA 4 stated, Kitchen staff is supposed to check the meal tray for accuracy. LVNS don't check resident's meal tray and I am not aware that nurses were supposed the tray before serving meals. During an interview on 6/21/24 at 10:12 a.m. with the DON, the DON stated, Licensed Nurses were required to check the trays prior to handing them out. The DON stated, The lunch is an order and licensed staff have to verify the order was followed by the kitchen prior to giving to the resident. During a 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 6/20/24, the AR indicated, Resident 2 was admitted from an acute care hospital on 4/18/24 to the facility, whose diagnoses included Hypertension (high blood pressure), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Peripheral Vascular Disease (PVD - a disorder that involves narrowing of the peripheral blood vessels),osteomyelitis (infection of the bone) to the left ankle and foot, Heart Failure (HF -the heart muscle doesn't pump blood as well as it should), and presence of Pace Maker (a small device that is inserted under the skin of your chest to help the heart beat in a regular rhythm). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/25/24, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 2 was cognitively intact. During a review of Resident 3's AR dated 6/20/24, the AR indicated Resident 3 was admitted from an acute care hospital on 7/14/21 to the facility, whose diagnoses included Dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), Dysphagia (trouble swallowing), Depression (a constant feeling of sadness and loss of interest, which stops you doing your normal activities), Anxiety (Feeling of being worried, tense or afraid), Dysphagia, Anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells), Hypertension, muscle weakness, and history of falling. During a review of Resident 3's MDS section C dated 4/24/24 the MDS indicated, Resident 3 had a BIMS score of 3 indicating Resident 3 had severe cognitive impairment. (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 review of Resident 4's AR dated 6/20/24, the AR indicated Resident 4 was admitted from an acute care hospital on 1/25/19 to the facility, whose diagnoses included Diabetes Mellitus (DM - A disease in which the body does not control the amount of glucose (a type of sugar) in the blood and the kidneys make a large amount of urine), Iron Deficiency Anemia, Intercranial Hemorrhage (type of stroke where blood pools between brain and skull preventing oxygen from reaching the brain), and Hypertension. During a review of Resident 4's MDS section C dated 5/7/24 the MDS indicated, Resident 4 had a BIMS score of 4 indicating Resident 4 had severe cognitive impairment. During a review of Resident 6's AR dated 6/2024, the AR indicated Resident 6 was admitted from an acute care hospital on 11/07/23 to the facility, whose diagnoses included Acute Respiratory Failure (a serious condition that makes it difficult to breathe on your own), Acute kidney failure (where your kidneys suddenly stop working properly), Atrial Fibrillation (a quivering or irregular heartbeat, or arrhythmia), Anemia, Hypertension, Encephalopathy (damage or disease that affects the brain), and history of falls. During a review of Resident 6's MDS section C dated 4/27/24 the MDS indicated, Resident 6 had a BIMS score of 12 indicating Resident 6 had mild cognitive impairment. During a review of Resident 10's AR dated 6/2024, the AR indicated Resident 6 was admitted from an acute care hospital on 10/25/19 to the facility, whose diagnoses included Dementia, Depression, Anxiety, and repeated falls. During a review of Resident 10's MDS section C dated 5/6/24 the MDS indicated, Resident 10 had a BIMS score of 00 indicating Resident 10 had severe cognitive impairment. During a review of Resident 11's AR dated 6/20/24, the AR indicated Resident 11 was admitted from her private residence on 8/02/23 to the facility, whose diagnoses included Depression, Neuropathy (nerve damage interfering with spinal cord), Anemia, Osteoarthritis (a degenerative joint disease, in which the tissues in the joint break down over time), and repeated falls. During a review of Resident 11's MDS section C dated 5/17/24 the MDS indicated, Resident 11 had a BIMS score of 15 indicating Resident 11 had no cognitive impairment. During a review of Resident 12's AR dated 6/20/24, the AR indicated Resident 11 was admitted from her private residence on 8/02/23 to the facility, whose diagnoses included DM, Anemia, Anxiety, Hypertension, Heart Failure (occurs when the heart muscle doesn't pump blood as well as it should), Atrial Fibrillation, and Morbid obesity (weight more than 80 to 100 pounds above their ideal body weight), due to excess calories. During a review of Resident 12's MDS section C dated 4/16/24 the MDS indicated, Resident 12 had a BIMS score of 14 indicating Resident 12 had no cognitive impairment. During a review of Resident 13's AR dated 6/20/24, the AR indicated Resident 13 was admitted from an acute care hospital on 8/02/23 to the facility, whose diagnoses included DM, Atrial Fibrillation, Heart Failure, Acute Kidney Failure, Hypertension, Acute Respiratory Failure, Anemia, Vitamin D Deficiency, muscle weakness, (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 review of Resident 13's MDS section C dated 5/15/24 the MDS indicated, Resident 13 had a BIMS score of 14 indicating Resident 13 had no cognitive impairment. During a review of Resident 14's AR dated 6/20/24, the AR indicated Resident 14 was admitted from a skilled nursing on 3/07/23 to the facility, whose diagnoses included Respiratory Failure, Acute Kidney Failure, Depression, Obesity, Cirrhosis (a condition in which the liver is scarred and permanently damage) of Liver, muscle weakness, Anemia, and repeated falls. During a review of Resident 14's MDS section C dated 5/09/24 the MDS indicated, Resident 14 had a BIMS score of 4 indicating Resident 14 has severe cognitive impairment. During a review of Resident 17's AR dated 6/20/24, the AR indicated Resident 17 was admitted from a skilled nursing on 01/05/22 to the facility, whose diagnoses included Dementia, Anemia, Vitamin D deficiency, Osteoarthritis to right hip, Anxiety, muscle weakness, and history of falling. During a review of Resident 17's MDS section C dated 5/22/24 the MDS indicated, Resident 17 had a BIMS score of 3 indicating Resident 17 has severe cognitive impairment. During a review of Resident 18's AR dated 6/20/24, the AR indicated Resident 18 was admitted from an acute care hospital on 05/04/24 to the facility, whose diagnoses included Depression, Atrial Fibrillation, Hypertension, Hemiplegia (paralysis that affects one side of your body) right side of body, Anemia, and history of falls. During a review of Resident 18's MDS section C dated 5/12/24 the MDS indicated, Resident 18 had a BIMS score of 15 indicating Resident 18 has no cognitive impairment. During a review of Resident 19's AR dated 6/20/24, the AR indicated Resident 19 was admitted from an assisted living home on 9/15/22 to the facility, whose diagnoses included Dementia, Hypertension, Vitamin D Deficiency, and Breast Cancer. During a review of Resident 19's MDS section C dated 5/31/24 the MDS indicated, Resident 19 had a BIMS score of 00 indicating Resident 19 has severe cognitive impairment. During a review of Resident 19's AR dated 6/20/24, the AR indicated Resident 19 was admitted from an assisted living home on 9/15/22 to the facility, whose diagnoses included Dementia, Hypertension, Vitamin D Deficiency, and Breast Cancer. During a review of Resident 21's AR dated 6/20/24, the AR indicated Resident 21 was admitted from an acute care hospital on 6/18/23 to the facility, whose diagnoses included DM, Depression, Huntington's Disease (The disease attacks areas of the brain that help to control voluntary (intentional) movement, as well as other areas), Anemia, and Dementia. During a review of Resident 21's MDS section C dated 3/25/24 the MDS indicated, Resident 21 had a BIMS score of 8 indicating Resident 21 has moderate cognitive impairment. (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 review of the facility's policy and procedure (P&P) titled, Food and Nutrition Services, dated 10/2017, indicated, . Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs . Nursing staff will ensure that assistive devices are available to residents as needed . During a review of Cal. Code Regs. Tit. 22, S 72309 - Nursing Service dated 3/10/22, Cal. Code Regs. Tit. 22, S 72309 - Nursing Service indicated, . 72311. Nursing Service-General . (a) Nursing shall include, but not be limited to, the following . (1) Planning of patient care, which shall include at least the following . (C) Licensed nursing personnel shall ensure that patients are served the diets as ordered by the attending licensed healthcare practitioner acting with the scope of his or her professional licensure .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555758	A. Building B. Wing	06/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Bethany Skilled Nursing	1441 Berkeley Dr Los Banos, CA 93635

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48430 Based on observation, interview, and record review, the facility failed to maintain an effective infection control program to prevent the development and transmission of diseases for seven of 18 sampled resident (Resident 128, 8, 1, 9 177, 16, and 19) when: 1. Resident 177 was on contact precautions and isolations gowns were not stocked and available outside the room for staff to use. 2. Certified Nurse Assistant (CNA) 1 did not use an alcohol-based hand rub (ABHR-an alcohol containing liquid, gel or foam rubbed on hands that kill microorganisms) when passing out breakfast trays for five of seven residents (Resident 128, 8, 1, 9, 177). 3. CNA 1 failed to use an ABHR prior to and after feeding two of two residents (Resident 16, 19). This failure had the potential to result in the transmission of infection between residents. Findings 1. During an observation on 6/18/24 at 10:51 a.m. outside Resident 177's room, there was an orange sign on the left side of the door that indicated Resident 177 was on contact isolation (a patient with a contagious disease that can spread by touch). Below the sign, an isolation cart (a container of gloves, gowns, and other protective coverings used for residents with infectious diseases) was missing isolation gowns (a protective gown worn by staff to prevent infections). During a concurrent observation and interview on 6/18/24 at 10:58 a.m. with Laundry Staff (LF) 1 in front of Resident 177's room, LF 1 stated, there should have been gowns stocked in the cart. During a concurrent observation and interview on 6/18/24 at 11:01 a.m. with CNA 2 outside Resident 177's room, CNA 2 stated, Resident 177 had shingles (a viral [a very small, disease-causing organism] disease that causes painful skin rashes). CNA 2 stated, there were no gowns in the cart and should have been re-stocked because Resident 177 was in contact isolation. CNA 2 stated, it's important to wear isolation gowns to prevent infections from spreading. During an interview on 6/20/24 at 10:26 a.m. with Infection Preventionist (IP), IP stated, Resident 177 was on contact isolation for shingles. IP stated, the isolation gowns outside Resident 177's room should have been stocked because the use of gowns and other protective equipment can help prevent the spread of infections. During an interview on 6/21/24 at 9:59 a.m. with the Director of Nursing (DON), the DON stated, the carts should have been stocked with gowns. The DON stated, Resident 177 had shingles and was in contact isolation. The DON stated, whenever a resident is on contact isolation, staff should always wear gowns, gloves, and other necessary protective equipment to ensure diseases do not spread to other residents. (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, Personal Protective Equipment-Using Gowns, dated October 2010, the P&P indicated, Objectives 1. To prevent the spread of infections; 2. To prevent soiling of clothing with infectious material .use of a gown is indicated, all personnel must put on the gown before treating or touching the resident. During a review of the facility's P&P titled, Isolation-Categories of Transmission-Based Precautions, dated 2001, the P&P indicated, Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room . 2. During an observation on 6/20/24 at 7:52 a.m. outside Resident 128's room, CNA 1 did not use an ABHR before or after when passing out the breakfast tray. During an observation on 6/20/24 at 7:54 a.m. outside Resident 8 room CNA 1 did not use an ABHR before or after entering the room when passing out the breakfast tray. During an observation on 6/20/24 at 7:55 a.m. outside Resident 1's room, CNA 1 did not use an ABHR before or after entering the room when passing out the breakfast tray. During an observation on 6/20/24 at 7:57 a.m. outside Resident 9's room, CNA 1 did not use an ABHR before or after entering the room when passing out the breakfast tray. During an observation on 6/20/24 at 7:58 a.m. outside Resident 177's room, CNA 1 did not use an ABHR before or after entering the room when passing out the breakfast tray. During an interview on 6/20/24 at 8:08 a.m. with CNA 1, CNA 1 stated, she didn't use an ABHR when she was passing out the trays because she didn't touch the residents. CNA 1 stated, they only use ABHRs when they touch the resident. During an interview on 6/20/24 at 8:15 a.m. with CNA 3, CNA 3 stated, every time CNAs go into each room and pass a tray, the must use an ABHR before and after. CNA 3 stated, if it was my mom, I'd want them [staff] to do that [use ABHR]. During an interview on 6/20/24 at 10:26 a.m. with IP, IP Nurse stated, CNA 1 should have used an ABHR for each resident whenever passing out trays. IP stated whenever a staff enters a room, they are expected to use an ABHR before entry, before care, after care, and before exiting the room. IP stated the use of ABHRs is important because it helps prevent the spread of pathogens (disease causing organisms) from one resident to the next. During an interview on 6/21/24 at 10:03 a.m. with the DON, the DON stated, it is expected for staff to use an ABHR whenever they are passing out food trays. The DON stated, even if staff just enters the room and hands out the tray, they must use an ABHR. The DON stated, the use of an ABHR is important because it's an infection control issue; it [ABHR] is used to help prevent infection and transmission of pathogens. (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 August 2019, the P&P indicated, All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing transmission of healthcare-associated infections, . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread o the infections to other personnel, residents, and visitors, . Use an alcohol-based hand rub .before and after direct contact with residents .after contact with objects .in the immediate vicinity of the resident .before and after eating or handling food .before and after assisting a resident with meals . 3. During an observation on 6/20/24 at 8:01 a.m. outside Resident 16's room, CNA 1 did not use an ABHR before proceeding to help Resident 16 eat breakfast. During an observation on 6/20/24 at 8:04 a.m. inside Resident 19's room, CNA 1 did not use an ABHR before starting to feed Resident 19 after feeding Resident 16. During an interview on 6/20/24 at 10:26 a.m. with IP, IP Nurse stated CNA 1 should have washed her hands or used an ABHR prior to feeding Resident 16 and Resident 19. IP stated the use of ABHRs is important because it helps prevent the spread of pathogens (disease causing organisms) from one resident to the next. During an interview on 6/21/24 at 10:03 a.m. with the DON, the DON stated, it is expected for staff to use an ABHR whenever they are passing out food trays. The DON stated, even if staff just enters the room and hands out the tray, they must use an ABHR. The DON stated, the use of an ABHR is important because it's an infection control issue; it [ABHR] is used to help prevent infection and transmission of pathogens. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated August 2019, the P&P indicated, All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing transmission of healthcare-associated infections, . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread o the infections to other personnel, residents, and visitors, . Use an alcohol-based hand rub .before and after direct contact with residents .after contact with objects .in the immediate vicinity of the resident .before and after eating or handling food .before and after assisting a resident with meals .