

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555758	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/05/2025
NAME OF PROVIDER OR SUPPLIER New Bethany Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Berkeley Dr Los Banos, CA 93635	
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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two of four sampled residents (Resident 9 and 23) when:1.The Nutritional assessment was not completed by the Registered Dietitian (RD) for Resident 9's significant change of condition assessment dated [DATE].This failure had the potential to put Resident 9 at an increased risk unavoidable significant weight loss. 2.Licensed Vocational Nurse (LVN) 1 did not assess Resident 23's pain prior to administering PRN (means as needed) pain medication (Acetaminophen - is a medication used to treat minor aches and pain and to reduce fever) on 9/3/25.This failure had the potential for Resident 23 not to receive an appropriate pain medication to effectively manage her pain. 3.LVN 1 did not check Resident 23's blood pressure and heart rate prior to administering a Metoprolol (a medication used to lower blood pressure and slows down heart rate) on 9/3/25. These failures had potential for Resident 23 to experience a negative effect such low blood pressure and heart rate. 1.During an observation on 9/2/25 at 9:45 a.m. with Resident 9, in Resident 9's room, Resident 9 was lying in bed, asleep. Resident 9's bedside table contained a full pitcher of water.During a concurrent observation and interview on 9/2/25 at 11:00 a.m. with Resident 9, in Resident 9's room, Resident 9 was awake, alert oriented to her name only. Resident 9 stated her name and declined to be interviewed. During an observation on 9/2/25 at 4:10 pm with Resident 9, in Resident 9's room, Resident 9 was slowly repositioning her body while lying in bed. Resident 9 was weak and closed her eyes.During an observation 9/3/25 7:10 a.m. with Resident 9, in Resident 9's room, Resident 9 was sleeping in bed.During a concurrent observation and interview on 9/3/25 at 12:40 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 9's room, CNA 2 placed Resident 9's lunch tray at bedside table. CNA 2 started feeding Resident 9 using a spoon. Resident 9 started to close her mouth when the spoon touched her lips. CNA 2 was giving a carton of health shake with a straw when Resident 9 immediately sipped the straw. CNA 2 offered a glass of red orange juice with a straw. Resident 9 tolerated drinking a glass of red juice using a straw. CNA 2 encouraged and offered the main meal and Resident 9 did not open her mouth and turned her head away from CNA 2. CNA 2 stated Resident 9 had been refusing her meals and liked to drink liquids. CNA 2 stated Resident 9 was always thirsty. CNA 2 stated Resident 9 was getting weak and not be able to get up in her wheelchair. CNA 2 stated Resident 9 had a decline in condition.During an interview on 9/4/25 at 10:04 a.m. with the RD, the RD stated she was not aware that Resident 9 had a significant change in condition and was admitted to hospice (a comprehensive care system for people with a terminal illness, focusing on maximizing comfort and quality of life rather than cure). The RD stated the Interdisciplinary Team (IDT) did not notify her about Resident 9's significant of condition. The RD stated Resident 9 had episodes of refusals of monthly weights and had poor oral intake. The RD stated Resident 9's nutritional assessment related to significant change of condition was not done. The RD stated Resident 9's nutritional assessment should be completed due to significant change of condition to appropriately intervene for a better outcome and quality of life of Resident 9. The RD stated Resident 9 had a significant weight loss from her last assessment. The RD stated nutritional care plan should be reviewed and updated to reflect Resident 9's significant change of condition. The RD stated the (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555758
		If continuation sheet Page 1 of 35

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	facility must continue providing care and addressing weight loss. During a review on 9/4/25 at 3:16 p.m. with Minimum Data Set Coordinator (MDSC), Resident 9's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Nutrition Risk Assessment, dated 6/5/25, Nurses Note, dated 6/26/25, Care Plan Report, undated, Weight Summary, dated 8/10/25, and Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 7/8/25, were reviewed. The Nutrition Risk Assessment indicated, .most recent weight 123 Date 4/3/25. The Nurses Note indicated, . admitted to hospice on 6/26/25. The Weight Summary indicated, weight 90 lbs. (pounds -unit of weight measurement) Date 8/10/25. The MDS indicated, . significant change of condition assessment ARD (Assessment Reference Date) 7/8/25. The MDSC stated Resident 9 was admitted to hospice on 6/26/25 and MDS Significant change of condition assessment was completed on ARD of 7/8/25. The MDSC stated the last Nutrition Risk Assessment was done on 6/5/25 and there was no Nutrition Risk assessment completed for MDS significant change of condition assessment. The MDSC stated the RD should complete a Nutrition Risk Assessment when Resident 9 had a significant change of condition assessment. The MDSC stated Resident 9 continued to have significant weight loss and continued to have meal refusals. During an interview on 9/4/25 at 3:50 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for the RD to complete a Nutritional Assessment related to Resident 9's MDS significant change of condition assessment. The DON stated it was important to assess the nutritional needs of the residents with significant weight loss to identify the root cause and implement interventions based on residents' nutritional needs. During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/5/25, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Essential Hypertension (HTN-high blood pressure), Anemia, Wedge Compression Fracture (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shape deformity), Transient Cerebral Ischemic Attack (TIA or mini stroke- is a temporary blockage of blood flow to the brain), Anemia (a condition where the body does not have enough healthy red blood cells), Metabolic Encephalopathy, Hypertensive Heart Disease (a condition where prolonged high blood pressure damages the heart muscle), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 9's MDS, dated [DATE], the MDS section C indicated Resident 9's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 9's BIMS Summary Score was blank. During a review of facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status, dated 2/21, the P&P indicated, . Policy Interpretation and Implementation - 2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and/or revision to the care plan. During a review of facility's P&P titled, Nutritional Assessment, dated 10/17, the P&P indicated, Policy Statement - As part of the comprehensive assessment, a nutritional assessment, including current nutritional status and risk factors for impaired nutrition, shall be conducted for each resident. Policy Interpretation and Implementation - 1. The dietitian, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicted by a charge in condition that places the resident at risk for impaired nutrition. 2. As part of the comprehensive assessment, the nutritional assessment will be a systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. 3. The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least the following components. d. Dietitian: (1) An estimate of calorie, protein, nutrient and fluid needs; (2) Whether the resident's current intake is adequate to meet his or her (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	outside Resident 23's room, LVN 1 prepared all 8:00 a.m. medications for Resident 23 on the top of the medication cart. LVN 1 went to Resident 23's room holding one medicine cup with eight tablets of medicine. LVN 1 stated, Knock, Knock, here are your meds, stated Resident 23's first name. Resident 23 identified herself and nodded. LVN 1 informed Resident 23 of the seven of seven medications including Metoprolol. Resident 23 took all the medications one at a time. LVN 1 did not check Resident 23's blood pressure and heart rate before giving the Metoprolol to Resident 23. During an interview on 9/2/25 at 10:30 a.m. with LVN 1, LVN 1 stated she did not check Resident 23's blood pressure and heart rate prior to administering the Metoprolol. LVN 1 stated she used the vital signs (are the measurements of the body's most basic functions such as body temperature, blood pressure, pulse rate and respiratory [breathing] rate) taken on 9/3/25 at 1:00 a.m. During a concurrent interview and record review on 9/4/25 at 1:27 p.m. with LVN 1, Resident 23's printed paper EMAR, dated 9/25, was reviewed. The EMAR indicated, Metoprolol Succinate ER (Extended Release). Give 1 tablet by mouth one time a day for palpitations (LVN 1 stated she checked Resident 23's blood pressure and heart rate on 9/3/25 at 2:03 p.m. and was recorded to EMAR. LVN 1 stated she should check Resident 23's blood pressure and heart rate before administering Metoprolol to know if the medication needed to be held. LVN 1 stated if blood and pressure or heart rate is too low, Metoprolol should not be given because the medication is used to lower blood pressure and heart rate. LVN 1 stated licensed nurses were responsible in checking vital signs, if necessary, before medication administration. During an interview on 9/4/25 at 5:23 p.m. with the DON, the DON stated it was her expectation for Licensed Nurses to check necessary vital signs before medication administration. The DON stated it was important and necessary to check blood pressure and heart rate before administering blood pressure medication. The DON stated blood pressure medication can lower the blood pressure and have the risk of making the blood pressure too low and can potentially cause cardiac arrest (a sudden, unexpected loss of heart function, breathing, and consciousness) for the residents. During a review of Resident 23's AR, dated 9/5/25, the AR indicated Resident 23 was admitted to the facility on [DATE] with primary other diagnosis of Chronic Atrial Fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), Cardiac Arrhythmia (improper beating of the heart, whether irregular, too fast, or too slow), and Essential Hypertension (HTN-high blood pressure). During a review of Resident 23's MDS section C indicated Resident 23 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 23 was cognitively intact. During a review of facility's P&P titled, Administering Medications, dated 10/22, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 11. The following information is checked/verified for each resident prior to administering medications. b. vital signs, if necessary. During a review of a professional reference titled, https://www.drugs.com/mtm/metoprolol-succinate-er.html, undated, indicated, Metoprolol . is used to treat angina (chest pain) and hypertension (high blood pressure). How should I take Metoprolol.? You will need frequent medical tests, and your blood pressure will need to be checked often. Call your doctor at once if you have: very slow heartbeats; a light-headed feeling, like you might pass out.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals used in the facility were stored and labeled in accordance with currently accepted professional standards for five of eight residents (Residents 1, 8, 20, 21 and 28) when: 1. Residents 1 ,8 , 20, 21 and 28's medications located in the medication cart had the room number of the residents listed and had no label with patient identifiers (information used by healthcare providers to accurately and reliably identify a patient like name and date of birth). These failures had the potential to result in a medication error (medication being given to the wrong patient).2. The medication room was widely open and unattended by authorized staff. This failure had the potential to result in unauthorized access and drug diversion (occurs when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed) of medications. 1.During a concurrent observation and interview on 9/4/25 at 10:11 a.m. with Licensed Vocational Nurse (LVN) 1, at the medication cart, LVN 1 unlocked and opened the medication cart that contained the facility's residents medications. A bottle of [joint health supplement] had 106B written on the bottle. LVN 1 stated the [joint health supplement] bottle was Resident 20's medication. A package containing artificial tears (medication to lubricate the eye) had 112A written on the package. LVN 1 stated the artificial tears were Resident 21's medication. A bottle of cetirizine hydrochloride tablets had 117 B written on the bottle. LVN 1 stated the bottle of cetirizine hydrochloride tablets was Resident 8's medication. A bottle of glucosamine chondroitin (a dietary supplement that works on maintaining the health of joints) caplets had 120B written on the bottle. LVN 1 stated the bottle of glucosamine chondroitin caplets was Resident 28's medication. Two bottles of [eye vitamin and mineral supplement] had 114A and 120 B written on them. LVN 1 stated the bottle with 114A was Resident 1's medication and the bottle with 120B was Resident 28's medication. A bottle of Vitamin D3 (a vitamin the body produces when exposed to sun light) capsules had 120B written on the bottle. LVN 1 stated the bottle of vitamin D3 capsules was Resident 28's medication. LVN 1 stated the process at the facility was to put the resident's room number on a patient specific medication if it was not an in-house (facility stock) medication. LVN 1 stated if the patient changed rooms, then the process was to put the new room number on the medication. During an interview on 9/4/25 at 4:02 p.m. with LVN 2, LVN 2 stated the practice at the facility when residents brought in their own over the counter medications was to write the room number on them. LVN 2 stated We don't have patient labels, maybe we should. LVN 2 stated it was important to use patient labels (label with patient name and date of birth) because it would be more secure than a room number. LVN 2 stated sometimes the residents moved rooms and there would be less room for error with a patient label. During an interview on 9/5/25 at 10:46 a.m. with the Director of Nursing (DON), the DON stated, the practice for labeling for resident specific over the counter medications was, Until now we have been putting the room number. The DON stated medications ordered by the physician and patient specific should have a patient identifiers name and date of birth . The DON stated if the medications did not have a patient label they could be given to another patient, and a medication error could happen. During a review of Resident 1's admission Record (AR) dated 9/5/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia (a progressive state of decline in mental abilities), Type 1 Diabetes (a disorder characterized by difficulty in blood sugar (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 9/3/25 at 11:10 a.m. with the RNS, at the nursing station, the RNS walked out from the nursing station and went to the medication room. The RNS closed the medication room and ensured the medication room was locked. The RNS stated the medication room was open and unattended. The RNS stated she didn't notice the medication room was open. The RNS stated the medication room should be locked at all times. During a concurrent observation and interview on 9/4/25 at 1:33 p.m. with the Licensed Vocational Nurse (LVN) 1, in the medication room, medications stored in the medication were checked. LVN 1 stated over-the-counter medications were stored on the top cabinets and discontinued medications were stored in the lower cabinets of the medication room. LVN 1 stated the medication room should be kept locked to prevent residents, families and visitors accessing the medication room. LVN 1 stated residents had the potential to take and consume the medications without the physician's order and put them at an increased risk of allergic reactions and potential side effects. LVN 1 stated only authorized staff have the medication room key including the Director of Nursing (DON), RNS, and Licensed Nurses. During an interview on 9/4/25 at 5:23 p.m. with the DON, the DON stated the medication room should be closed and locked at all times. The DON stated medications and medical supplies like syringes were stored in the medication room. The DON stated that when the medication room was left open, anyone can access the medications and medical supplies. The DON stated residents can take the medicine and can harm themselves for any sharp objects stored in the medication room. The DON stated taking medication without a physician's orders can potentially cause side effects. During a review of facility's policy and procedures (P&P) titled, Medication, Labeling and Storage, dated 2001, the P&P indicated, The facility stores all medications and biologicals in locked compartments. Only authorized personnel have access to keys. Policy Interpretation and Implementation: Medication storage 4. Compartments (including, but not limited to drawers, cabinets, rooms.) containing medications and biologicals are locked when not in used. or otherwise potentially available to others. During a review of facility's P&P titled, Medication Room Policy, undated, the P&P indicated, Purpose: The medication room shall be maintained as secure, clean, and restricted-access area intended only for the storage and preparation of medications and approved medical supplies. Medication room must remain locked at all times when not in use.		

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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. Based on observation, interview, and record review, the facility failed to ensure food was stored and prepared in accordance with professional standards for food services safety for 29 of 29 sampled residents when:1. A portion of Chicken meat was not fully submerged in water while thawing under running water2. The dishwasher had built up white residue on the surface and black dirt and debris on the top surfaceThese failures placed residents at risk for foodborne (sickness resulting from contaminated food) illness and food contamination.1. During a concurrent observation and interview on 9/2/25 at 9:00 a.m. with [NAME] 1, chicken meat was being thawed under running water, a portion of the meat was not fully submerged under water or in the path of the running water. [NAME] 1 stated the meat should have been fully submerged under water or in the path of the running water. [NAME] 1 stated submerging the meat helped ensure it thawed at a safe temperature and helped prevent the meat from being exposed to contaminants (substances that can make the food impure) that may fall on the meat.During an interview on 9/4/25 at 9:50 a.m. with the Dietary Services Supervisor (DSS), the DSS stated the chicken should have been fully submerged under water while being thawed. The DSS stated when thawing meat it was important to ensure its being thawed at the same temperature throughout so that no part of the meat heats up to a point it can harbor bacteria. The DSS stated bacteria can start to contaminate meat between 40 to 140 degrees Fahrenheit (F). The DSS stated submerging the meat also helped remove any contaminants and food particles that may be present on the meats surface. The DSS stated improperly thawing meat could lead to residents receiving foodborne illnesses.During an interview on 9/4/25 at 10:07 a.m. with the Registered Dietitian (RD), The RD stated meat being thawed under running water should be submerged fully under the water. The RD stated if the meat did not fit in the bowl being used, kitchen staff should have placed it in a bigger container. The RD stated it was important for the meat to be submerged while being thawed under running water so it does not reach an unsafe temperate range which could potentially make the residents sick.During a review of the facility's policy and procedure (P&P) titled, Thawing of Meats, dated 2023, the P&P indicated, . Submerge under running water, potable water at a temperature of 70 degrees F or lower, with a pressure sufficient to flush away loose particles .During a review of the United States Food and Drug Association's Food Code, dated 2022, the Food Code indicated when thawing food under running water, the food should be completely submerged under running water with sufficient water velocity to agitate and float off loose particles in an overflow and to prevent the meat from rising above 41 degrees F for more than four hours.2. During a concurrent observation and interview on 9/2/25 at 9:25 p.m. with Dietary Aide (DA) 1, the kitchen's dishwasher had a build up of white residue on the surface and black and brown dirt and debris on the top. DA 1 stated the dishwasher should have been cleaned. All parts of the dishwasher need to be in a clean state because any debris on the dishwasher can fall on the clean dishes and contaminate the residents' food.During an interview on 9/4/25 at 9:50 a.m. with the DSS, the DSS stated the dishwasher should be regularly maintained in a clean condition. The dishwasher should have been cleaned daily otherwise any debris could cross contaminate (when bacteria are transferred from one surface to another) the clean dishes and cause the residents to get sick if they eat off those dishes. The residents in the facility are more vulnerable than most people and they can easily receive a foodborne illness.During an interview on 9/4/25 at 10:07 a.m. with the RD, The RD stated the dishwasher should be in a cleaned state because that is where the dishes are sanitized. The RD stated if the area was not clean the facility could risk the food contact area to be unsanitary and lead to cross contamination for the residents.During a review of the facility's P&P titled, Sanitation, dated 2023, the P&P indicated, . The Food and Nutrition Services (FNS) director is responsible for instructing Food & Nutrition Services personnel in the use of equipment. Each employee shall know how to operate and clean all equipment in his specific work area . All utensils, counters, shelves, and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	equipment shall be kept clean, maintained in good repair . The kitchen staff is responsible for all the cleaning.During a review of the USFDA Food Code dated 2022, the Food Code indicated, . 4-602.13 Nonfood-Contact Surfaces. The presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food .		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility failed to implement the quality assurance performance improvement (QAPI- a meeting where staff members come together to talk about ways to improve the quality of care for patients and prevent problems before they happen) plan for 29 of 29 sampled residents when the Registered Dietitian's (RD) QAPI recommendation to be involved in Interdisciplinary Team (IDT- a collaborative meeting where professionals from various disciplines [such as doctors, nurses, therapists, and social workers], come together to discuss and coordinate care for an individual) meetings were not followed. This failure had the potential to have resident weight changes go unmonitored by the RD. During an interview on 9/4/25 at 10:07 a.m. with the RD, the RD stated she has emailed the facility her QAPI report and recommendations for the facility to implement. The RD stated she has recommended to be involved in the facility's IDT meetings, but no action has been taken. The RD stated she would like to be invited to the meetings to better be informed about resident weight loss and any new conditions they may have. During a concurrent interview and record review on 9/5/25 at 2:58 p.m. with the Administrator (ADM) and the Director of Nursing (DON), The RD's QAPI report titled, Quality Assessment for Performance Improvement Summary and Recommendations, dated, 1/16/25 and 1/23/25, indicated . IDT monthly weight meetings are not happening . RD requests skin reports but they are not given to RD . The RD's report dated 4/1/25 indicated, . RD is not included in IDT weight meetings . Info regarding residents with skin issues is provided by nursing when RD requests but is not provided to RD without asking for it . The RD's report dated 5/23/25 indicated, . IDT Weight meetings each month, including the RD and Dietary Services Supervisor (DSS), may be beneficial so IDT team can discuss interventions for residents . RD is not included in IDT weight meetings . The RD's report dated 6/20/25 indicated, . IDT weight meetings each month, including the RD and DSS, may be beneficial so IDT team can discuss interventions for residents . RD is not included in IDT weight meetings . The ADM stated the RD sends her report and recommendations for the QAPI committee via email since she cannot attend physically due to other obligations and it was the responsibility of the DON and ADM to present the RD's report and follow her recommendations during QAPI. The DON stated they did not document any attempt to get the RD involved in IDT meetings. The ADM stated they did not follow the RD's recommendations to be involved in IDT meetings. The ADM stated it was important for the RD to be involved in IDT meetings because the facility did not want to have any unaddressed weight loss or wounds to occur or worsen for any resident. During a review of the facility's policy and procedure (P&P) titled, QAPI Program, undated, indicated, . QAPI program is an facility wide program which focuses ongoing improvements for all depts . QAPI will address: 1. Clinical care issues by reviewing QI/QM measurements, consultant reports, staff feedback to identify areas of concern/opportunity for growth.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections in the medication room and for two of two sampled residents (Residents 3 and 15) when 1.Licensed Vocational Nurse (LVN) 1 stored her personal belongings inside of the medication room on the medication counter. 2. Resident 15's oxygen nasal cannula (NC - a plastic tube used to deliver oxygen) was stored in an open package.3. Resident 3's NC was stored in the top drawer of the resident's nightstand with no packaging to protect it from the environment. These failures had the potential to result in cross contamination (the process by which germs are unintentionally transferred from one substance or object to another, with harmful effect).1.During a concurrent observation and interview on 9/4/25 at 9:33 a.m. with Registered Nurse Supervisor (RNS), in the medication room, an open bag and a large drink container were sitting on the medication counter. Inside the bag were 2 small drink containers and a wallet. The RNS stated the bag and water container belong to a nurse. The RNS stated staff do not normally store personal belongings inside the medication room. The RNS stated the facility did not encourage staff to store personal belongings inside the medication room but there were circumstances that were allowed. The RNS stated she did not know if the nurse had her own locker to store her personal belongings in. The RNS stated she did not know the exact policy regarding personal belongings being stored in the medication room. During a concurrent observation and interview on 9/4/25 at 9:59 a.m. with LVN 1, in the medication room, an open bag and a large drink container were sitting on the medication counter. Inside the bag were 2 small drink containers and a wallet. LVN 1 stated the bag, the drink containers and wallet were her personal belongings. LVN 1 stated she normally kept her drinks in the medication room on the counter. LVN 1 stated the medication room was the only space available to put her belongings. LVN 1 stated she did not have a staff locker. LVN 1 stated she did not know the facility's policy regarding personal belongings in the medication room. During an interview on 9/5/25 at 5:30 p.m. with the Director of Nursing (DON), the DON stated the practice at the facility was that staff could not store personal belongings on medication room counters. The DON stated personal belongings were not allowed on the medication room counter because it was an infection control (practice of stopping germs from spreading and making people sick) issue. The DON stated that when personal belongings were stored in the medication room on the counter it could contaminate (make something dirty, spoiled or unsafe by introducing a harmful substance) the medication. During a review of the facility's policy and procedure (P&P) titled, Medication Room Policy (undated) the P&P indicated, To ensure the safe, secure, and organized storage of medications, supplies, and related items within the medication room in compliance with federal, state and facility regulations. The medication room shall be maintained as a secure, clean and restricted-access area intended only for the storage and preparation of medications and approved medical supplies.Staff CN [Charge Nurse] may place personal belonging under sink. 2. During an observation on 9/2/25 at 10:20 a.m. in Resident 15's room, Resident 15 was observed with an oxygen NC stored in an open package sitting on top of the oxygen concentrator (a medical device that provides oxygen). (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 9/4/25 at 2:39 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated, oxygen tubing had to be labeled with the date when they start to use it so that staff know when it had to be changed. CNA 4 stated the NC had to be sealed because if it was open it was contaminated. CNA 4 stated if the resident used it, the resident could get an infection. CNA 4 stated if she found an open bag with NC tubing in it, CNA 4 would report it to the nurse and the tubing should be thrown away. During an interview on 9/4/25 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, when the bag containing oxygen tubing is opened, it should be dated. LVN 2 stated it was important to change the NC tubing because the tubing will get dirty and contaminated after a certain time. LVN 2 stated the tubing needed to be changed out to keep clean for the resident because germs, bacteria, and infection can occur otherwise. During an interview on 9/5/25 at 10:19 a.m. with the Director of Nursing (DON), the DON stated, NC tubing came sealed in the original package and once it is opened it needed to be put into another bag sealable bag. The DON stated, once the original package was opened, it was usually dated with the open date and the nurse puts their initials on it. The DON stated, NC tubing should be stored enclosed and protected so it does not get contaminated. During a review of Resident 15's admission Record (AR) dated 9/5/25, the AR indicated Resident 15 was admitted to the facility on [DATE] with diagnosis of Hypertensive (high blood pressure) Heart Disease with Heart Failure, Chronic (continuing for a long time) Kidney Disease, Interstitial (relating to spaces between cells, tissues, or organs in the body) Pulmonary (relating to or affecting the lungs) Disease. During a review of Resident 15's Order Summary Report(OSR), dated 9/5/25, the OSR indicated, Other Admit under [hospice company] care.Notify MD [medical doctor] of change of condition promptly, O2 [oxygen] via nasal cannula or face mask at 2L [L-a unit of measure]/min[minute] prn [as needed] for dyspnea [shortness of breath] . During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 11/3/2008, the P&P indicated, General Infection Control Guidelines.Gather equipment, maintaining sterility and cleanliness.Thoroughly clean all equipment used and return to appropriate storage area. 3. During a concurrent observation and interview on 9/4/25 at 2:46 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 3's room, a nasal cannula was in Resident 3's nightstand in the top drawer. The nasal cannula was out of the sterile package and was touching the inside of the drawer. CNA 4 stated, Resident 3's nasal cannula was out of the package should have been stored sealed. CNA 4 stated when a nasal cannula package was opened it had to be dated. CNA 4 stated Resident 3 could get an infection if the nasal cannula was used on her. CNA 4 stated if the nasal cannula is out of its package it is contaminated. During an Interview on 9/4/25 at 3:42 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, an outside agency delivered Resident 3's oxygen supplies. LVN 2 stated when the nasal cannula is first used it is dated and after use it is stored in a resealable plastic bag to keep it clean. LVN 2 stated if the nasal cannula was not clean the resident could get sick from germs, bacteria and infections. During an Interview 9/5/25 at 10:19 a.m. with the Director of Nursing (DON), The DON stated, once a nasal cannula is out of it original package it should be stored enclosed and protected in another bag (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	so it does not get contaminated. The DON stated, if a nasal cannula was in a drawer it is contaminated and should be thrown out. The DON stated when a nasal cannula was in a drawer without a package the resident could get an infection. During a review of Resident 3's admission Record (AR) dated 9/5/25, the AR indicated, Resident was admitted to the facility on [DATE] with Cerebral Infarction (tissue death caused by a lack of blood supply to the brain), Hypertensive Chronic Kidney Disease (kidney damage caused by long-term high blood pressure), and Acute Respiratory Failure with Hypoxia (lungs suddenly can't get enough oxygen into the blood). During a review of Resident 3's Order Summary Report (OSR), dated 9/5/25, the OSR indicated start date. 3/10/2025 [oxygen] via NC [nasal cannula] at 2l/min [2 liters a minute] as needed. Active. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 11/3/2008, the P&P indicated, General Infection Control Guidelines. Gather equipment, maintaining sterility and cleanliness. Thoroughly clean all equipment used and return to appropriate storage area.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote the rights of the residents, and treat residents with respect and dignity for two of three sampled residents (Resident 7 and 22) when1.The facility did not use an alternate communication method with non-English speaking resident (Resident 7) such as language assistance, communication card, interpreters or translated materials. This failure violated Resident 7's rights to understand the care provided to her in a language she understood and had the potential to result in Resident 7's needs to go unmet.2.Resident 22 was waiting to be fed by the nursing staff while watching another resident eating lunch meal at the same table on [DATE]. This failure violated Resident 22's right to be treated with respect and dignity in a manner which recognized each resident's individuality. 1.During a concurrent observation and interview on [DATE] at 3:39 p.m. with the Activities Director (AD) in the activities room, Resident 7 was up in a wheelchair at a table coloring on paper. The AD stated, she communicated with Resident 7 by using [technology company] translate. During a concurrent observation and interview on [DATE] at 2:50 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 7's room, CNA 4 looked through Resident 7's room/belongings but was unable to find a communication card. CNA 4 stated, Resident 7 spoke Russian. CNA 4 stated when staff had a hard time understanding Resident 7 staff would use [technology company] translate on their phone. During an interview on [DATE] at 3:47 p.m. with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated, she usually spoke English to Resident 7. LVN 2 stated if the conversation was more complicated or if Resident 7 became frustrated, she would use the [technology company] translation app on the phone. LVN 2 stated the facility had a communication card, but she had never used it with Resident 7. During a concurrent interview and record review on [DATE] at 9:05 a.m. with the LVN/Minimum Data Set Coordinator (MDSC), Resident 7's Care Plan Report (CPR) dated, [DATE] was reviewed. The CPR indicated, . The resident has an interpretation need. Speaks Russian, speaks and understands simple [English] . Goal . The resident will communicate via interpreter when needed . Interventions . Resident's preferred language is: Russian . Use communication card so she can point to what she needs . The LVN/MDSC stated, Resident 7 spoke Russian Primarily. The LVN/MDSC stated Resident 7 spoke a little English and staff used [technology company] translate a lot. The LVN/MDSC stated staff do not use the communication card, they use the translation app on the phone. The LVN/MDSC stated Resident 7's Care Plan indicated her preferred language was Russian. The LVN/MDSC stated the facility had a policy and procedure for non-English speaking residents. The LVN/MDSC stated she did not know that the facility's policy and procedure was for non-English speaking residents. During an interview on [DATE] at 10:23 a.m. with the Director of Nursing (DON), the DON stated, Resident 7 could say a few words in English. The DON stated staff at the facility used [technology company] translate to communicate with Resident 7. The DON stated the facility had no translator service. The DON stated the facility did have any staff that spoke Russian. The DON stated, it was possible for Resident 7 to not get her needs met when the facility did not use a translator. During an interview on [DATE] at 5:17 p.m. with the DON, the DON stated the communication card was on the care plan and should have been implemented so staff could better understand Resident 7. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated if staff did not use the communication board Resident 7 would not be able to verbalize her needs. During a review of Resident 7's admission Record dated [DATE], the admission Record indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses of Vascular Demetia Mild (condition where minor damage to blood vessels in the brain causes subtle problems with thinking and memory) and Hypertensive Heart and Chronic Kidney Disease without Heart Failure (long-term high blood pressure has damaged both heart and kidneys) possibly add more dx from other side. During a review of the facility's policy and procedure (P&P) titled, Language Barrier Policy and Procedure (undated), he P&P indicated, . Communicating with a language barrier must identifying communication needs, providing access to qualified interpreters, and ensuring that all translated materials are clear and accurate. It is crucial to document all communication preferences and efforts to provide language assistance in the resident's medical record . Providing interpreter services . Qualified Interpreters: must provide residents with access to qualified interpreters or all critical medical communications, including discussing diagnoses, treatment plans, and obtaining consent . Interpreter options: have a system for providing timely interpreter services. Options include: Video Remote interpreting: Using video calls for real-time interpretation. Over-the Phone Interpreting: An on-demand service for a wide range of languages . Communication Boards . 2. During an observation on [DATE] at 11:55 a.m. in the dining room, Resident 22 was sitting in a wheelchair holding a baby doll on her left arm in front of the table. Resident 22's lunch meal tray was served by the nursing staff. Resident 22 was clean and well groomed. Resident 22 could not maintain direct eye contact and was unable to verbally respond during conversation. During a concurrent observation and interview on [DATE] at 12:00 p.m. with Certified Nursing Assistant (CNA) 1, in the dining room, CNA 1 started feeding a resident beside Resident 22. CNA 1 stated she will feed the three residents sitting at the table one at a time. CNA 1 stated she cannot feed two residents at the same time due to infection control issue. CNA 1 stated residents requiring one on one assistance with meals will wait for their turn to be fed by the CNAs. During an observation on [DATE] at 12:10 p.m. with Resident 22, in the dining room, Resident 22 was reaching for a glass of red juice in her tray. CNA 1 assisted Resident 22 holding a glass of red juice. Resident 22 drank half a glass of red juice. During an observation on [DATE] at 12:15 a.m. with Resident 22, in the dining room, Resident 22 was sitting in a wheelchair in front of the table with lunch meal tray. Resident 22 was opening the cover of the lunch plate. Resident 22 was able to remove the plate cover halfway from the plate and started touching the mashed potatoes with her right-hand fingers. Resident 22's right hand fingers with mashed potatoes residue were put on her mouth. Resident 22 started getting restless (inability to rest or relax as a result of anxiety [feeling of uneasiness or worry] or boredom) and repeatedly biting the clothing of the baby doll on her left arm. During an observation on [DATE] at 12:20 p.m. with Resident 22, in the dining room, Resident 22's plate was completely open. Resident 22 was waiting for her turn to be fed by CNA 1. Resident 22 continuously biting the clothing of the baby doll on her left arm. During a concurrent observation and interview on [DATE] at 12:30 p.m. with CNA 1, in the dining room, CNA 1 placed Resident 22's plate in the microwave and started feeding Resident 22. CNA 1 (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated Resident 22 requires one on one assistance with eating. CNA 1 stated Resident 22 should not wait for her turn to be fed while another resident was eating. CNA 1 stated Resident 22 should not be watching another resident eating. During an interview on [DATE] at 10:54 a.m. with CNA 1, CNA 1 stated the three residents in the table require one on one assistance with meals. CNA 1 stated Resident 22 and the rest of the residents in table should be fed at the same time by a CNAs. CNA 1 stated Resident 22 should feel that this is their home and should be treated with respect. CNA 1 stated when my family was eating out, we need to wait for all the family members will be served and will start eating at the same time, and stated, It is a sign of respect. During an interview on [DATE] at 4:15 p.m. with the Director of Nursing (DON), DON stated residents requiring one-on-one assistance with eating should be assisted by CNAs during meals. The DON stated Resident 22 should be fed by another CNA at the same time as other residents at the table. The DON stated there should be one CNA assigned for each of the residents on the table. The DON stated Resident 22 should not be waiting for her turn and watching other residents eating. The DON stated the Activity Director (AD) was also CNA and she was assigned in the Dining Room to assist with meals. The DON stated she was disappointed it had happened to Resident 22. The DON stated Resident 22, and all residents had the right to be treated with respect and dignity and stated, This is their home. The DON stated all residents should be treated with respect and dignity. During an interview on [DATE] at 9:10 a.m. with the Restorative Nursing Assistant (RNA), the RNA stated the facility does not have RNA Eating Program for the residents. The RNA stated CNAs were responsible in assisting residents that require one on one assistance with meals. The RNA stated Resident 22 requires one on one assistance with meals. The RNA stated residents that require assistance with eating should be fed by different CNAs at the same time. The RNA stated The RNA stated you don't eat, and others are watching you eating at home. The RNA stated this is their home and all residents should be treated with respect and dignity. During a review of Resident 22's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 22 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Aphasia (a disorder that makes it difficult to speak), Osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), Anxiety Disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), and muscle weakness. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 22's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 22's BIMS Summary Score was blank. During a review facility's policy and procedures (P&P) titled, Resident's Rights, dated, 2/21, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation 1. Federal and state law guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence; b. be treated with respect, kindness, and dignity; .		

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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** Based on observation, interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan for two of six sampled residents (Resident 7 and 9) when:1.The facility did not use an alternate communication method with non-English speaking resident (Resident 7) such as language assistance, communication card, interpreters or translated materials.This failure violated Resident 7's rights to understand the care provided to her in a language she understood and had the potential to result in Resident 7's needs to go unmet.2. Resident 9's fall care plan intervention to minimize fall related injuries was not implemented. Resident 9 did not have bilateral floor mats on the sides of the bed.This failure had the potential to place Resident 9 at an increased risk of an avoidable fall and obtaining fall-related injuries. 1.During a concurrent observation and interview on [DATE] at 3:39 p.m. with the Activities Director (AD) in the activities room, Resident 7 was up in a wheelchair at a table coloring on paper. The AD stated, she communicated with Resident 7 by using [technology company] translate. During a concurrent observation and interview on [DATE] at 2:50 p.m. with Certified Nursing Assistant (CNA) 4, in Resident 7's room, CNA 4 looked through Resident 7's room/belongings but was unable to find a communication card. CNA 4 stated, Resident 7 spoke Russian. CNA 4 stated when staff had a hard time understanding Resident 7 staff would use [technology company] translate on their phone. During an interview on [DATE] at 3:47 p.m. with the Licensed Vocational Nurse (LVN) 2, LVN 2 stated, she usually spoke English to Resident 7. LVN 2 stated if the conversation was more complicated or if Resident 7 became frustrated, she would use the [technology company] translation app on the phone. LVN 2 stated the facility had a communication card, but she had never used it with Resident 7. During a concurrent interview and record review on [DATE] at 9:05 a.m. with the LVN/Minimum Data Set Coordinator (MDSC), Resident 7's Care Plan Report (CPR) dated, [DATE] was reviewed. The CPR indicated, . The resident has an interpretation need. Speaks Russian, speaks and understands simple [English] . Goal . The resident will communicate via interpreter when needed . Interventions . Resident's preferred language is: Russian . Use communication card so she can point to what she needs . The LVN/MDSC stated, Resident 7 spoke Russian Primarily. The LVN/MDSC stated Resident 7 spoke a little English and staff used [technology company] translate a lot. The LVN/MDSC stated staff do not use the communication card, they use the translation app on the phone. The LVN/MDSC stated Resident 7's Care Plan indicated her preferred language was Russian. The LVN/MDSC stated the facility had a policy and procedure for non-English speaking residents. The LVN/MDSC stated she did not know that the facility's policy and procedure was for non-English speaking residents. During an interview on [DATE] at 10:23 a.m. with the Director of Nursing (DON), the DON stated, Resident 7 could say a few words in English. The DON stated staff at the facility used [technology company] translate to communicate with Resident 7. The DON stated the facility had no translator service. The DON stated the facility did have any staff that spoke Russian. The DON stated, it was possible for Resident 7 to not get her needs met when the facility did not use a translator. During an interview on [DATE] at 5:17 p.m. with the DON, the DON stated the communication card was on the care plan and should have been implemented so staff could better understand Resident 7. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON stated if staff did not use the communication board Resident 7 would not be able to verbalize her needs. During a review of Resident 7's admission Record dated [DATE], the admission Record indicated, Resident 7 was admitted to the facility on [DATE] with diagnoses of Vascular Demetia Mild (condition where minor damage to blood vessels in the brain causes subtle problems with thinking and memory) and Hypertensive Heart and Chronic Kidney Disease without Heart Failure (long-term high blood pressure has damaged both heart and kidneys) possibly add more dx from other side. During a review of the facility's policy and procedure (P&P) titled, Language Barrier Policy and Procedure (undated), he P&P indicated, . Communicating with a language barrier must identifying communication needs, providing access to qualified interpreters, and ensuring that all translated materials are clear and accurate. It is crucial to document all communication preferences and efforts to provide language assistance in the resident's medical record . Providing interpreter services . Qualified Interpreters: must provide residents with access to qualified interpreters or all critical medical communications, including discussing diagnoses, treatment plans, and obtaining consent . Interpreter options: have a system for providing timely interpreter services. Options include: Video Remote interpreting: Using video calls for real-time interpretation. Over-the Phone Interpreting: An on-demand service for a wide range of languages . Communication Boards . 2. During an observation on [DATE] at 9:45 a.m. with Resident 9, in Resident 9's room, Resident 9 was lying in bed, asleep. Resident 9's room had two floor mats against the wall by the door. Resident 9's bed with bed alarm (a sensor that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) and no floor mats (a floor pad designed to help prevent injury should a person fall) on the floor. During a concurrent observation and interview on [DATE] at 11:00 a.m. with Resident 9, in Resident 9's room, Resident 9 was awake, alert oriented to her name only. Resident 9 stated her name and declined to be interviewed. Resident 9's floor mats were not on the floor. Resident 9's floor mats were placed against the wall by Resident 9's room door. During an observation on [DATE] at 4:10 pm with Resident 9, in Resident 9's room, Resident 9 was positioning her body while lying in bed. Resident 9 had no floor mats placed on the floor. Resident 9's floor mats were placed against the wall by the room door. During an observation [DATE] 7:10 a.m. with Resident 9, in Resident 9's room, Resident 9 was sleeping in bed with no floor mats on the floor. Resident 9's floor mats were placed against the wall by the room door. During a concurrent observation and interview on [DATE] at 9:20 a.m. with Licensed Vocational Nurse (LVN) 1, in Resident 9's room, LVN 1 removed the two floor mats from the wall and placed on the floor on both sides of Resident 9's bed. LVN 1 stated the two floor mats should be in place on the floor not on the wall. During a concurrent interview and record review on [DATE] at 11:00 a.m. with LVN 1, Resident 9's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Order Summary Report, dated [DATE] was reviewed. The Order Summary Report indicated, . Floor mats to be placed on floor on sides of bed every shift. LVN 1 stated the physician's order for Resident 9's floor mats must be followed to minimized fall related injurie. LVN 1 stated the two floor mats should be placed (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on both sides of Resident 9's bed. LVN 1 stated Resident 9 was at a high risk for falls and had a history of multiple falls with minor injuries. LVN 1 sated resident had unpredictable behaviors of attempting to get out of bed and agitation (a condition in which a person in unable to relax and be still). During an interview on [DATE] at 11:15 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated Resident 9 had fallen from bed and in a wheelchair and Resident 9 sustained an injury. CNA 2 stated he remembered Resident 9 having a bruise on her face because of the fall. CNA 2 stated Resident 9 is at risk for falls and had attempted to get out of bed. CNA 2 stated floor mats should be placed on both sides of Resident 9's bed to decrease the level of injuries related to a fall. During a concurrent interview and record review on [DATE] 5:17 p.m. with the Director of Nursing (DON), Resident 9's EMR titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, .The resident is Moderate Risk for falls related to confusion, deconditioning, gait and balance problems.Goals: The resident will be free of falls through the review date.Interventions: Floor mat to be placed on floor on sides of bed . The DON stated Resident 9 should have floor mats on each side of bed as stated on Resident 9's fall care plan. The DON stated Resident 9's fall care plan interventions should be implemented and followed by staff to achieve the goal of preventing falls and sustaining injuries related to the falls. The DON stated Resident 9 was at risk of falls. During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Essential Hypertension (HTN-high blood pressure), Anemia, Wedge Compression Fracture (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shape deformity), Transient Cerebral Ischemic Attack (TIA or mini stroke- is a temporary blockage of blood flow to the brain), Hypertensive Heart Disease (a condition where prolonged high blood pressure damages the heart muscle), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 9's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 9's BIMS Summary Score was blank. During a review of facility's policy and procedures (P&P) titled, Falls and Fall Risk, Managing, dated 2001, the P&P indicated, . Policy Statement &ndash; Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and try to minimize complications from falling. Policy Interpretation and Implementation. Resident-Centered Approaches to Managing Falls and Fall Risk &ndash; 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Monitoring Subsequent Falls and Fall Risk &ndash; 1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risk of falling.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pharmaceutical services which ensured appropriate receipt, reconciliation and identification of controlled drugs (medications with potential for abuse or addiction and are required by federal law to be accounted for by Licensed Nurses) for two of seven sampled residents (Residents 10 and 14) when Licensed Nurses did not verify and ensure completion of the controlled drug record upon receipt from the pharmacy. This failure had the potential for drug diversion (drugs used illegally) of controlled substance medications. During an interview on 9/5/25 at 10:49 a.m. with the Director of Nursing (DON), the DON stated, the practice at the facility when controlled drugs were delivered was that the Licensed Nurse would check the manifest with the medication and the Licensed Nurse should sign the controlled drug record if all was correct. During a concurrent interview and record review on 9/5/25 at 3:47 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 14's Controlled Drug Record (CDR) dated 8/16/25 was reviewed. The CDR indicated, [Resident 14 . HYDROCODONE - [acetaminophen] 5 MG 325 MG [milligram -unit of measurement] TABLET . GIVE 1 TAB BY MOUTH EVERY 6 HOURS AS NEEDED . Quantity 30 Date 8/16/25 . Signature [blank area no signature] . LVN 3 stated the process at the facility was when a nurse received a controlled drug delivery, the nurse needed to sign the CDR. LVN 3 stated Resident 14's CDR was missing a nurses signature and should have been signed. During a concurrent interview and record review on 9/5/25 at 3:50 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 10's CDR (undated), was reviewed. The CDR indicated, SIGNATURE OF NURSE RECEIVING MEDICATION: [blank area no signature] Date [blank area no date] No. [number of] doses received: [blank area no number] . [Resident 10] 30 LORAZEPAM 0.5 MG TABLET TAKE 1 TABLET BY MOUTH EVERY 4 HOURS AS NEEDED FOR ANXIETY/AGITATION . LVN 3 stated Resident 10's CDR was missing a nurses signature. LVN 3 stated Resident 10's CDR should have been signed by a nurse. During an interview on 9/5/25 at 4:13 p.m. with the Consultant Pharmacist (CP), the CP stated, stated he had been consulting remotely for months and had not been on site due to health issues. The CP stated when controlled drugs were received at the facility the process was for the Licensed Nurse to sign the controlled drug record. The CP stated it was important for the nurse to sign the controlled drug record to prevent drug diversion. During a review of Resident 10's admission RECORD (AD - a comprehensive snapshot of a person's personal, medical and social status completed when admitted to a facility), dated 9/5/25, the AR indicated , Resident # was admitted to the facility on [DATE] with diagnosis of Atherosclerotic Heart Disease (fatty deposits build up inside the arteries, narrowing them and making it harder for blood and oxygen to reach organs), Unspecified Dementia (a group of brain disorders that cause progressive decline in memory and thinking) and Encounter for Palliative Care (specialized medical care that focuses on providing relief from pain and other symptoms of serious illness. During a review of Resident 10's Order Summary Report (OSR) dated 9/5/25, the OSR indicated, Resident 10 had an order for lorazepam 0.5 milligram (MG - unit of measurement) one tablet by mouth every four hours as needed for anxiety/agitation with a start date of 9/3/25. During a review of Resident 14's AR dated 9/5/25, the AR indicated, Resident # was admitted to the facility on [DATE] with diagnosis of Fracture [break in bone] of upper and lower end of the right fibula [long bone in the lower extremity], Diabetes Mellitus [too much sugar in the blood] due to Underlying Condition with Diabetic Neuropathy [nerve damage caused by diabetes] and Dorsopathy [pain in the back]. During a review of Resident 14's OSR dated 9/5/25, the OSR indicated, Resident 14 had an order for hydrocodone-acetaminophen oral tablet 25 MG 1 tablet by mouth every six hours as needed for pain started on 8/12/25. During a review of the facility's policy and procedure (P&P) titled, Controlled Substances dated 11/2022, the P&P indicated, Controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	count the controlled substances together. Both individuals sign the designated controlled substance record . If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving a controlled substance . This record contains: . Signature of person receiving medication . signature of nurse administering medication . Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow up . The consultant pharmacist or designee routinely monitors controlled storage records .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the resident's representative in writing of the transfer to the General Acute Care Hospital (GACH) for one of three sampled residents (Resident 33) when Resident 33 was transferred to the GACH on 7/4/2025 and his Responsible Party (RP - a person responsible for another person's healthcare decisions) was not informed of the reason for the transfer. This failure resulted in the lack of written notification for Resident 33's change in condition. During an interview on 9/6/25 at 8:18 a.m. with the License Vocational Nurse/Director of Staff Development (LVN/DSD), the LVN/DSD stated, Resident 33 was transferred to a GACH on 7/4/25. The LVN/DSD stated Resident 33's RP was given verbal notice of Resident 33's transfer to the hospital on 7/4/25. The LVN/DSD stated Resident 33's RP was not provided with a written notice of Resident 33's transfer to the acute hospital. The LVN/DSD stated she was not aware a written notice was required whenever a resident gets transferred to GACH. The LVN/DSD stated it was important for the facility to provide a written notification of the reason for the transfer to GACH to the resident and their RP to ensure they fully understand why the transfer was necessary for Resident 33's care needs. During a review of Resident 33's TRANSFER/DISCHARGE REPORT (TDR), dated 7/4/25, the TDR indicated, . CHIEF COMPLAINT (reason for transfer) Sudden change in baseline Sent to [acute hospital] for further [evaluation] . During a review of Resident 33's Progress Notes (PN) dated 7/4/25, the PN indicated, . Transfer to Hospital Summary . Resident appears to have sudden change in baseline. Resident not properly holding food in his mouth, appears pale, and weak. [name of doctor] notified via phone and gave following order: Send [acute hospital] [emergency room] via [company name] ambulance for further evaluation. Spoke with resident RP regarding resident's current status and agreeable to send resident to hospital. Resident left facility at [1:44 p.m.] in a gurney accompanied by two paramedics . During an interview on 9/6/25 at 11:00 a.m. with the Director of Nursing (DON) the DON stated, the practice at the facility was for the nurse to call the family and indicate the reason why the resident was being transferred to the hospital. The DON stated the practice at the facility did not include notifying the residents or the residents representative in writing of a transfer. During a review of Resident 33's admission Record (AR) dated 9/5/25, the AR indicated, Resident 33 was admitted to the facility on [DATE] with diagnoses of Heart Failure (a condition where the heart muscle is weakened and cannot pump blood effectively), Atrial Flutter (irregular heartbeat) and Cardiomegaly (enlarged heart). During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, Facility Initiated dated October 2022, the P&P indicated, . Facility-initiated transfers and discharges, when necessary, must meet specific criteria and require resident/representative notification and orientation, and documentation as specified in this policy . Notice of Transfer or Discharge (Emergent or Therapeutic Leave) . When residents are sent emergently to an acute care setting, these scenarios are considered facility-initiated transfers . Under the following circumstances, the notice is given as soon as practicable but before the transfer . An immediate transfer or discharge is required by the resident's urgent medical needs .		

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a comprehensive person-centered care plan to reflect assessments and interventions to address a significant change of condition for one of three sampled residents (Resident 9) when Resident 9's care plans were not updated and revised after completion of significant change of condition assessment. 1. Resident 9's nutritional care plan was not revised to reflect Resident's 9's significant change of condition assessment dated [DATE]. 2. Resident 9's activities care plan was not revised to reflect Resident's 9's significant change of condition assessment dated [DATE]. These failures had the potential for Resident 9 not to receive the necessary care and services and put Resident 9 at an increased risk of not having her needs met. 1. During an observation on 9/2/25 at 9:45 a.m. with Resident 9, in Resident 9's room, Resident 9 was lying in bed, asleep. Resident 9's bedside table contained a full pitcher of water. During a concurrent observation and interview on 9/2/25 at 11:00 a.m. with Resident 9, in Resident 9's room, Resident 9 was awake, alert oriented to her name only. Resident 9 stated her name and declined to be interviewed. During an observation on 9/2/25 at 4:10 pm with Resident 9, in Resident 9's room, Resident 9 was slowly repositioning her body while lying in bed. Resident 9 was weak and closed her eyes. During an observation 9/3/25 7:10 a.m. with Resident 9, in Resident 9's room, Resident 9 was sleeping in bed. During a concurrent observation and interview on 9/3/25 at 12:40 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 9's room, CNA 2 placed Resident 9's lunch tray at bedside table. CNA 2 started feeding Resident 9 using a spoon. Resident 9 started to close her mouth when the spoon touched her lips. CNA 2 was giving a carton of health shake with a straw when Resident 9 immediately sipped the straw. CNA 2 offered a glass of red orange juice with a straw. Resident 9 tolerated drinking a glass of red juice using a straw. CNA 2 encouraged and offered the main meal and Resident 9 did not open her mouth and turned her head away from CNA 2. CNA 2 stated Resident 9 had been refusing her meals and liked to drink liquids. CNA 2 stated Resident 9 was always thirsty. CNA 2 stated Resident 9 was getting weak and not be able to get up in her wheelchair. CNA 2 stated Resident 9 had a decline in condition. During an interview on 9/4/25 at 10:04 a.m. with the Registered Dietitian (RD), the RD stated she was not aware that Resident 9 had a significant change in condition and was admitted to hospice (a comprehensive care system for people with a terminal illness, focusing on maximizing comfort and quality of life rather than cure). The RD stated Resident 9 had episodes of refusals of monthly weights and had poor oral intake. The RD stated the Interdisciplinary Team (IDT) did not notify her about Resident 9's significant change of condition. The RD stated Resident 9's nutritional assessment related to significant change of condition was not done. The RD stated Resident 9's nutritional assessment should be completed due to significant change of condition to appropriately intervene for a better outcome and quality of life of Resident 9. The RD stated Resident 9 had a significant weight loss from her last assessment. The RD stated nutritional care plan should be reviewed and updated to reflect Resident 9's significant change of condition. The RD stated the facility must continue providing care and addressing weight loss. During a review on 9/4/25 at 3:16 p.m. with Minimum Data Set Coordinator (MDSC), Resident 9's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, undated, Nurses Note, dated 6/26/25, Weight Summary, dated 8/10/25, and Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 7/8/25, were reviewed. The Care Plan Report indicated, .at risk for weight loss, malnutrition (a state of poor nutritional health that occurs when the body does not receive or utilize sufficient nutrients to maintain optimal growth, development, and health), and dehydration (a state of fluid deficiency in the body, where the body loses more water than it takes in). Goal: The resident will maintain adequate nutritional status as evidenced by maintaining weight within 5% (percentage) of 118, no signs and symptoms (s/s) of malnutrition and consuming at least 2-3 meals (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER New Bethany Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Berkeley Dr Los Banos, CA 93635	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily. Interventions: RD to evaluate to evaluate and make diet change recommendations PRN (as needed). On 6/20/24, RD recommended NAS (No Added Salt) CCHO (Consistent Carbohydrate Diet) diet, mechanical soft . The Nurses Note indicated, . admitted to hospice on 6/26/25. The Weight Summary indicated, weight 90 lbs. (pounds -unit of weight measurement) Date 8/10/25. The MDS indicated, . significant change of condition assessment ARD (Assessment Reference Date) 7/8/25. The MDSC stated Resident 9 was admitted to hospice on 6/26/25 and MDS Significant change of condition assessment was completed on ARD of 7/8/25. The MDSC stated Resident 9's nutritional care plan was not reviewed and updated when Resident 9 was admitted to hospice and MDS Significant change of condition assessment was completed. The MDSC stated Resident 9's care plan should be reviewed and revised to reflect the current significant change of condition assessment. The MDSC stated Resident 9 continued to have significant weight loss and continued to have meal refusals. During an interview on 9/4/25 at 3:50 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for the IDT to review and revise a care plan when residents had a significant change of condition assessment. The DON stated Resident 9's nutritional care plan should be reviewed and revised due to Resident 9's significant weight loss and when resident was admitted to hospice. The DON stated comprehensive-person centered care plan should be developed and updated based on current residents' assessment for staff to provide the right care for the residents. During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/5/25, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Essential Hypertension (HTN-high blood pressure), Anemia, Wedge Compression Fracture (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shape deformity), Transient Cerebral Ischemic Attack (TIA or mini stroke- is a temporary blockage of blood flow to the brain), Anemia (a condition where the body does not have enough healthy red blood cells), Metabolic Encephalopathy, Hypertensive Heart Disease (a condition where prolonged high blood pressure damages the heart muscle), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys).During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/8/25, the MDS section C indicated Resident 9's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 9's BIMS Summary Score was blank.During a review of facility's policy and procedures (P&P) titled, Change in a Resident's Condition or Status, dated 2/21, the P&P indicated, . Policy Interpretation and Implementation - 2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and/or revision to the care plan.During a review of facility's P&P titled, Resident Assessments, dated 10/23, the P&P indicated, A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Sets (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. Policy Interpretation and Implementation. 12. Information in the MDS Assessments will consistently reflect information in the progress notes, plans of care .During a review of facility's P&P titled, Weight Assessment and Intervention. Resident weights are monitored for undesirable or unintended weight loss or gain. Evaluation - 1. Undesirable weight change is evaluated by the treatment team whether or not the criteria for the significant weight change has been met. Care Planning - 1. Care Planning for weight loss or impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist, and the resident or resident's legal surrogate. 2. Individualized care plans shall address to the extent possible: a. the identified causes pf weight loss; b. goals and benchmarks for improvement. 2. During an observation on 9/2/25 at 9:45 a.m. with Resident 9, in (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 9's room, Resident 9 was lying in bed, asleep. Resident 9's bedside table contained a full pitcher of water. During a concurrent observation and interview on 9/2/25 at 11:00 a.m. with Resident 9, in Resident 9's room, Resident 9 was awake, alert oriented to her name only. Resident 9 stated her name and declined to be interviewed. During an observation on 9/2/25 at 4:10 pm with Resident 9, in Resident 9's room, Resident 9 was slowly repositioning her body while lying in bed. Resident 9 was weak and closed her eyes. During an observation 9/3/25 7:10 a.m. with Resident 9, in Resident 9's room, Resident 9 was sleeping in bed. During an interview on 9/4/25 at 3:16 p.m. with the MDSC, the MDSC stated Resident 9's activities care plan was not reviewed and updated when Resident 9 had MDS significant change of condition assessment completed. The MDSC stated Resident 9's care plan should be reviewed and revised to reflect the current significant change of condition assessment. During an interview on 9/4/25 at 3:50 p.m. with the DON, the DON stated it was her expectation for the IDT to review and revise a care plan when residents had a significant change of condition assessment. The DON stated comprehensive-person centered care plan should be developed and updated based on current residents' assessment for staff to provide the right care for the residents. During a concurrent interview and record review on 9/5/25 at 9:31 a.m. with the Activities Director (AD), Resident 9's EMR titled, Care Plan Report, undated, was reviewed. The Care Plan Report indicated, Altered Participation in Activities due to wandering (roaming). Goal: Resident will attend and participate in 1-2 30-minute event daily. The AD stated the activities care plan was not revised and updated to reflect Resident 9's current assessment. The AD stated Resident 9 had a significant change of condition. The AD stated Resident 9 had been staying in bed and no longer wandering. The AD stated the activity staff provide one-on-one room visits and hand massages to Resident 9. The AD stated Resident 9's activities care plan should be person-centered and she needed to update Resident 9's activities care plan. During a review of Resident 9's AR, dated 9/5/25, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Essential Hypertension (HTN-high blood pressure), Anemia, Wedge Compression Fracture (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shape deformity), Transient Cerebral Ischemic Attack (TIA or mini stroke- is a temporary blockage of blood flow to the brain), Anemia (a condition where the body does not have enough healthy red blood cells), Metabolic Encephalopathy, Hypertensive Heart Disease (a condition where prolonged high blood pressure damages the heart muscle), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 9's MDS, dated [DATE], the MDS section C indicated Resident 9's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 9's BIMS Summary Score was blank. During a review of facility's P&P titled, Change in a Resident's Condition or Status, dated 2/21, the P&P indicated, . Policy Interpretation and Implementation - 2. A significant change of condition is a major decline or improvement in the resident's status that: c. requires interdisciplinary review and/or revision to the care plan. During a review of facility's P&P titled, Resident Assessments, dated 10/23, the P&P indicated, A comprehensive assessment of each resident is completed at intervals designated by ORBA regulations and PPS requirements. Data from the Minimum Data Sets (MDS) is submitted to the Internet Quality Improvement Evaluation System (IQIES) as required. Policy Interpretation and Implementation. 12. Information in the MDS Assessments will consistently reflect information in the progress notes, plans of care .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure nail care was provided for one of three sampled residents (Resident 9) when Resident 9's fingernails were long and dirty with brownish dirt built up underneath the nails. This failure had potential for Resident 9 in obtaining avoidable skin related injuries (including cuts (laceration), scrapes (abrasion), scratches, etc.) and infection (the invasion and growth of germs in the body). During a concurrent observation and interview on 9/2/25 at 11:00 a.m. with Resident 9, in Resident 9's room, Resident 9 was awake, alert oriented to her name only. Resident 9 stated her name and declined to be interviewed. Resident 9's left hand fingernails are long and dirty with brownish dirt built up underneath the nails mostly on left thumb finger. Resident 9's right hand was tucked underneath the blanket. During a concurrent observation and interview on 9/4/25 2:35 p.m. with Certified Nursing Assistant (CNA) 2, in Resident 9's room, Resident 9's fingernails on both hands were checked. CNA 2 stated Resident 9's fingernails on both hands were long and dirty with brownish dirt built up underneath the nails. CNA 3 attempted to remove the brownish dirt built up underneath the nail of Resident 9's thumb using a handmade cone shaped paper without resistance from Resident 9. CNA 2 stated, . it was dirty. CNA 2 stated CNAs and activity staff were responsible in doing nail care every week. CNA 2 stated Resident 9 was allowing him to provide care for her, including nail care. CNA 2 stated Resident 9 was dependent on staff to carry out activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, personal hygiene, and toileting a person performs daily to care for themselves). During an interview on 9/4/25 at 1:45 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated activity staff and CNAs were responsible in doing nail care weekly. LVN 1 stated Licensed Nurses also check residents' nails to ensure their nails are trimmed and cleaned to prevent infection. During an interview on 9/4/25 at 5:23 p.m. with the Director of Nursing (DON), the DON stated Resident 9's fingernails should be trimmed and cleaned. The DON stated activity staff and CNAs were assigned to provide nail care to all residents. The DON stated long, and dirty fingernails can harbor microorganisms (bacteria) that can cause infection. The DON stated long fingernails can cause self-inflicting skin injuries like skin scratches. During a review of Resident 9's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/5/25, the AR indicated Resident 9 was admitted to the facility on [DATE] with diagnosis of Dementia (a progressive state of decline in mental abilities), Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), Essential Hypertension (HTN-high blood pressure), Anemia, Wedge Compression Fracture (a type of spinal fracture where the front part of the vertebra collapses, creating a wedge-shape deformity), Transient Cerebral Ischemic Attack (TIA or mini stroke- is a temporary blockage of blood flow to the brain), Hypertensive Heart Disease (a condition where prolonged high blood pressure damages the heart muscle), and Chronic Kidney Disease (a disease characterized by progressive damage and loss of function in the kidneys). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/8/25, the MDS section C indicated Resident 9's BIMS - was not conducted with a code of 0 indicating No (resident is rarely/never understood). Resident 9's BIMS Summary Score was blank. During a review of facility's policy and procedure titled, Fingernails/Toenails, Care of, dated, 2/18, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching his or her skin.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a hearing device was in placed to maintain resident's hearing abilities for one of three sampled residents (Resident 1) when Resident 1 had not been using a left ear implant hearing device (a surgical device that restores or improves hearing in individuals with severe hearing loss or deafness). This failure had resulted in Resident 1 experiencing a difficulty in hearing during conversation with staff and other residents and having the potential not to effectively communicate his needs with the staff. During an observation on 9/2/25 at 12:00 p.m. with Resident 1, in the dining room, Resident 1 was sitting in a wheelchair in front of the table waiting for his lunch meal. Resident 1 was alert and oriented to his name. Resident 1 was pleasant, clean and well groomed. Resident 1 had difficulty hearing during the conversation. During a concurrent observation and interview on 9/2/25 at 12:05 p.m. with Certified Nursing Assistant (CNA) 3, in the dining room on Resident 1's table, CNA 3 served and set up Resident 1's lunch meal tray. CNA 3 was talking to Resident 1 close to his right ear and stated Resident 1 had difficulty hearing. During an interview on 9/2/25 at 12:44 p.m. with Resident 1, in the dining room, Resident 1 had difficulty hearing during conversation and was instructed to talk closer to his right ear. Resident 1 stated both of his ears were impaired and his right ear was better today (9/2/25). During an interview on 9/4/25 at 2:42 p.m. with Resident 1, in Resident 1's room, Resident 1 stated both ears had been impaired with his right ear weaker than left ear. Resident 1 stated he had an implant to his right ear and stated, I need a battery. Resident stated he had episodes of hearing difficulty and asked staff to talk closer to his left ear. Resident 1 stated he had his own ear specialist. During an observation and interview with CNA 2, in Resident 1's room, CNA 2 was talking to Resident 1 and CNA 1 repeated the information by talking closer to Resident 1's left ear. CNA 2 was checking Resident 1's left ear implant. CNA 1 stated the ear implant looked like a button and no device was connected. CNA 2 stated Resident 1 told him that his left ear implant requires a battery changed to hear adequately and clearly. CNA 2 stated he was not aware that Resident 1 had a left ear implant. During a concurrent interview and record review on 9/4/25 at 3:47 p.m. with the Director of Nursing (DON), Resident 1's Electronic Medical Records (EMR- a digital version of a patient's paper chart) titled Nurses Note, dated 3/25/25 and 7/8/25, and Care Plan Report, undated were reviewed. The Nurses Notes indicated a left ear implant. The Care Plan Report did not indicate a left ear implant. The DON stated Resident 1's left ear implant was identified during the admission and care plan should be developed and implemented. The DON stated the left ear implant should be addressed by the Interdisciplinary Team (IDT) to ensure Resident 1 receives proper treatment and services in maintaining hearing abilities. The DON stated licensed nurses were responsible in initiating, reviewing, and communicating the care plan to the CNAs. During an interview on 9/5/25 at 8:32 a.m. with the Social Services Director/Medical Records, the SSD/MR was not aware of Resident 1's hearing difficulty and the presence of left ear implant. The SSD/MR stated licensed nurses were responsible in doing hearing evaluation. During a concurrent interview and record review on 9/5/25 at 5:30 p.m. with Minimum Data Set Coordinator (MDSC), Resident 1's EMR titled, Care Plan Report, undated, was reviewed. The Care plan Report indicated, .The resident has impaired hearing function .Goal: The resident will show no decline in hearing function. Interventions: Implant hearing device near left ear. revision date 9/5/25. The MDSC stated the care plan for left ear implant hearing devices was revised on 9/5/25 after communicating with resident's representative on 9/4/25. The MDSC stated care plan should be developed upon identification on left ear implant on admission. The MDSC stated the care plan was important for staff to be aware of residents' care to effectively communicate with the residents. The MDSC stated Resident 1's need of hearing device should be identified upon admission for Resident 1 to adequately hear and can connect with staff and other residents. During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care (continued on next page)		

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

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	providers, family contact information and other pertinent information), dated 9/5/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with primary diagnosis of Malignant Neoplasm of Prostate (commonly known as Prostate Cancer-is a growth of abnormal cells that starts in the prostate). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/25/25, the MDS section C indicated Resident 1 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 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was moderately impaired. During a review of facility's policy and procedures (P&P) titled, Hearing Impaired Resident, Care of, Staff will assist hearing impaired residents to maintain effective communication with clinician, caregivers, other residents and visitors. Policy Interpretation and Implementation 3. Staff will assist residents with care and maintenance of hearing devices.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure each resident received and was provided food that accommodates the resident's preferences or provide a substitute meal of similar nutritive value for two of three residents (Residents 1 and 25) when1. Resident 1 was served and consumed non-fortified substitute/alternative food during lunch on 9/2/25.2. Resident 25 disliked gravy and was provided lunch with gravy, ate 10 percent of the meal, and was not offered a substitute meal at lunch on 9/2/25. This failure had the potential for Residents 1 and 25 not meeting the calories required to maintain the weight and nutritional status and placed Residents 1 and 25 at risk for avoidable significant weight loss. 1.During an observation on 9/2/25 at 12:00 p.m. with Resident 1, in the dining room, Resident 1 was sitting in a wheelchair in front of the table waiting for his lunch meal. Resident 1 was alert and oriented to his name. Resident 1 was pleasant, clean and well groomed. Resident 1 had difficulty hearing during the conversation. During a concurrent observation and interview on 9/2/25 at 12:05 p.m. with Certified Nursing Assistant (CNA) 3, in the dining room on Resident 1's table, CNA 3 served and set up Resident 1's lunch meal tray. CNA 3 was talking to Resident 1 close to his right ear and stated Resident 1 had difficulty hearing. CNA 3 stated Resident 1 refused to eat his lunch meal tray and requested bread. CNA 3 stated Resident 1 was requesting a grilled cheese sandwich. During an interview on 9/2/25 at 12:12 p.m. with CNA 3, in the dining room, CNA 3 stated Resident 1 cannot have bread per the kitchen staff. CNA 3 stated Resident 1 was offered substitute food and Resident chose chicken noodle soup. During an observation on 9/2/25 at 12:18 pm with Resident 1, in the dining room, Resident 1 received a small bowl of chicken noodle soup. Resident 1 opened the bowl cover and started eating the chicken noodle soup. During a review of Resident 1's, Tray Card (document which outlines resident's ordered diet for Breakfast, Lunch, and Dinner), undated, the Tray Card indicated, .Fortified Mechanical Soft Level 5. During a concurrent observation and interview on 9/2/25 at 12:44 p.m. with Resident 1, in the dining room, Resident 1 had consumed a one bowl of chicken noodle soup. Resident 1 had difficulty hearing during conversation and was instructed to talk closer to his right ear. Resident 1 stated both of his ears were impaired and his right ear was better. Resident 1 stated he didn't like his lunch meal; the food was not the same as home cooked food. Resident 1 stated his wife had been cooking his food for 73 years. During an interview on 9/5/25 at 10:22 a.m. with CNA 3, CNA 3 stated Resident 1 had episodes of refusing his lunch meal. CNA 3 stated we offer food substitutes when Resident 1 refused his meal and followed food preferences. CNA 3 stated she didn't understand the reason for the kitchen declining Resident 1's request for grilled cheese sandwich. During an interview on 9/5/25 at 10:41 a.m. with the Dietary Services Supervisor (DSS), the DSS stated the Fortified diet included extra calories and nutrients in residents' meals to prevent weight loss. The DSS stated facility does not have a fortified diet menu for food alternatives. The DSS stated fortified diet was only for the main meal and not for alternatives. The DSS stated the Dietary [NAME] (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(DC) prepared and made the chicken noodle soup for Resident 1 on 9/2/25. DSS stated chicken noodle soup is a regular soup and not a fortified. During concurrent interview and record review on 9/5/25 at 10:45 a.m. with the DSS, the facility's FORTIFIED MENU PLAN, dated 6/22 was reviewed. The FORTIFIED MENU PLAN indicated, . Soup per menu Extra 1/2 oz (ounces- a unit of weight measurement) melted margarine, or Top with 1 Tbsp shredded cheese, or 1 Tbsp protein powder. The DSS stated the Fortified Diet Menu plan for the soup to be considered fortified, extra margarine should be added. The DSS stated she cannot locate the posting of the Fortified Menu Plan inside the kitchen. The DSS stated the Fortified Menu Plan should be posted in the kitchen for the staff to reference. During an interview on 9/5/25 at 11:00 a.m. with the DC, the DC stated he prepared and cooked the chicken noodle soup for Resident 1 on 9/2/25. The DC stated Resident 1's chicken noodle soup was a regular chicken noodle soup and not fortified. The DC stated he was not aware that Resident 1 was on a Fortified diet. The DC stated he did not check Resident 1's diet. The DC stated he should check Resident 1's diet before preparing the food. The DC stated it was his responsibility to make sure Resident 1 was receiving the prescribed fortified diet to get all the calories he needed to prevent him from losing weight. During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 9/5/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with primary diagnosis of Malignant Neoplasm of Prostate (commonly known as Prostate Cancer-is a growth of abnormal cells that starts in the prostate). Resident 1 had other diagnosis of Diverticulosis of Intestine (a condition in which small, bulging pouches develop in digestive tract), and Type 1 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 7/25/25, the MDS section C indicated Resident 1 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 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 6 was moderately impaired. During a review of Resident 1's, electronic medical record (EMR- a digital version of a patient's paper chart) titled, Order Summary Report, dated 9/5/25, the Order Summary Report indicated, . Dietary &ndash; Diet Order Summary Fortified Diet Mechanical Soft texture. During a review of Resident 1's EMR titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, .at risk for weight loss, malnutrition, and dehydration.Goal: The Resident will maintain adequate nutritional status. Interventions: Honor food preferences within diet order. Provide, serve diet as ordered: Fortified diet. During an interview on 9/4/25 at 10:04 a.m. with the Registered Dietitian (RD), the RD stated the facility had the policy and procedures (P&P) for Fortified diet and dietary department had a fortified diet menu. The RD Fortified diet means adding extra calories to maintain residents' weight and nutritional status. The RD stated the Fortified diet includes the main meal and food substitutes. The RD stated serving chicken noodle soup was not a fortified diet. The RD stated a food substitute can (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER New Bethany Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 1441 Berkeley Dr Los Banos, CA 93635	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be fortified and should be fortified for residents on Fortified diet. The RD stated there was There is a fortified menu plan for food substitutes. The RD stated if the resident refused the Fortified diet meal, the resident should be served with a fortified food substitute. The RD stated the dietary department should follow the Fortified Diet Menu Plan. During a review of facility's P&P titled, Fortified Diet, dated 2023, the P&P indicated, The fortified diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status. NUTRITIONAL BREAKDOWN: The goal is to increase the calorie density of the foods commonly consumed by the residents. The amount of calorie increase should be approximately 300-400 per day. FOODS: Examples of adding calories may include &ndash; Extra margarine or butter to food items.Add cheese to soups, pasta, or vegetables.During a review of Food and Nutrition Services In-service titled, Inservice: Fortified Diets, dated 4/25/25, the Inservice: Fortified Diets indicated, .Fortified diets are for residents who cannot consume adequate amounts of calories to maintain their weight or nutritional status. This can put them at risk for weight loss, skin breakdown, or loss of muscle mass. If a resident is on a Fortified Diet and gets an alternative, the ALTERNATIVE MUST BE FORTIFIED. 2.During a concurrent observation and interview on 9/2/25 at 12:16 p.m. in the dining room, Resident 25 was sitting up in a wheelchair at a table. Resident 25 had a plate in front of him that included chicken covered with a thick yellowish liquid substance, peas, and potatoes. Resident 25 stated the thick liquid substance was gravy. Resident 25 stated he did not like gravy. During a concurrent observation and interview on 9/2/25 at 12:35 p.m. in the dining room, Resident 25 was sitting up in a wheelchair eating lunch. Resident 25 had a plate with chicken, peas and potatoes. Resident 25 stated he only ate a little of the potatoes and was finished eating. Resident 25 stated he did not like the peas or the gravy on his plate. During an observation and interview on 9/2/25 at 12:50 p.m. with Certified Nursing Assistant (CNA) 1, in the dining room, Resident 25 was sitting in a wheelchair at a table accompanied by CNA 1. CNA 1 asked Resident 25 why he did not want to eat or drink his lunch. Resident 25 stated he did not like the food to CNA 1. CNA 1 offered Resident 25 fluids before picking up the lunch tray. CNA 1 did not offer a substitute meal. CNA 1 stated the thick liquid substance on Resident 25's lunch plate looked like white gravy on the chicken. CNA 1 stated Resident 25 did not like gravy. CNA 1 stated Resident 25 ate 10 percent of his meal. CNA 1 stated she sometimes offered substitute food when Resident 25 did not eat much of his meal but did not offer Resident 25 a substitute today. During an interview on 9/4/25 at 3:33 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, the process at the facility when a resident dislikes food is, dietary services would come and speak to the patient and then write what the resident dislikes on a card that came with the meals. LVN 2 stated when meals are ready to be served a meal check is done in the kitchen by staff, then a nurse checks the meals to ensure they are correct. LVN 2 stated it was important to honor the residents' preferences. LVN 2 stated if she was served food she disliked she would probably not want it and would go hungry. LVN 2 stated there was a potential for residents to lose weight or have other health problems if they were served food they did not like. LVN 2 stated staff should offer a substitute if a resident did not eat their meal. LVN 2 stated the CNA should notify the kitchen staff and ask the residents what they preferred as an alternative. LVN 2 stated it was important to offer a substitute meal so the residents would be satisfied. LVN 2 stated residents could lose weight and have other health issues when they were not offered a substitute meal. (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 9/4/25 at 5:05 p.m. with the Dietary Services Supervisor (DSS), Resident 25's Cardex (undated) was reviewed. The Cardex indicated, Dislikes: Breakfast: Gravy Lunch & Dinner Gravy. The DSS stated a resident's likes and dislikes were recorded on the Dietary Profile on the computer. The DSS stated the Dietary Profile was where the DSS kept track of the residents food preferences. The DSS stated the purpose of the Cardex card on the table during meals was to show the resident's food preferences. The DSS stated Resident 25 was served peas, meat with gravy, and potatoes at lunch on 9/2/25. The DSS stated Resident 25 should not have received gravy with his lunch meal because it is his preference not to have gravy. DSS stated if a resident is served a disliked food, there was a potential for the resident to not eat and stated there was a possibility the resident could lose weight. DSS stated her expectation when a resident was served food they disliked was to offer an alternative meal. The DSS stated chicken without gravy was an option for Resident 25. The DSS stated was important for alternatives to be offered so that the resident, Can eat something and not go hungry. The DSS stated the resident could potentially not receive enough nutrients and could start losing weight. During an interview on 9/5/25 at 10:19 a.m. with the Director of Nursing (DON), the DON stated, ensuring a resident's food preferences was the responsibility of the Dietary Supervisor and the Registered Dietician. The DON stated if a resident was served food they did not like they would not eat it. The DON stated, when a resident did not eat their meal because they were served food they did not like, weight loss could happen. The DON stated she expected the kitchen staff to provide a substitute meal when a resident did not eat their meal. During a review of Resident 25's admission Record (AR) dated 9/5/25, the AR indicated, Resident 25 was admitted to the facility on [DATE] with diagnoses of Unspecified Dementia (progressive state of decline in mental abilities), Gastro-Esophageal Reflux Disease (when stomach contents including acid flow back up into the muscular hollow tube that carries food and liquid from the throat to the stomach) without esophagitis (an inflamed, swollen, or irritated muscular hollow tube that carries food and liquid from the throat to the stomach) , and Anemia, unspecified (a condition where the body does not have enough healthy red blood cells). During a review of Resident 25's Order Summary Report (OSR), dated 9/5/25, the OSR indicated, Dietary-Diet Order Summary NAS (No Added Salt) diet Mechanical Soft Texture, Regular consistency, Level 5-Minced and Moist.Dietary- Supplements Order Summary House nourishment-4 oz.[a unit of measure] two times a day for supplement.Other Order Summary Plate Guards (an eating aid that attaches to the rim of a plate to help scoop food and prevent spills) for meals. During a review of Resident 25's Cardex, (undated), the Cardex indicated, [Resident name and room number] Diet NAS Mech. Soft Level 5 Minced & Moist Plate Guard.Dislikes: Breakfast: Gravy Lunch & Dinner Gravy. During a review of Resident 25's Good For Your Health Menus, dated September 1-7, 2025, the Good For Your Health Menu indicated, Tuesday September 2.Chicken with [NAME] Sauce Boiled Red Potatoes Seasoned Peas Cornbread Ice Cream. During a review of Resident 25's Dietary Profile, dated Effective Date: 9/3/25, the Dietary Profile indicated, .K. Likes/Dislikes 1. Likes [blank space on document] 2. Dislikes [blank space on document] . During a review of the facilities policy and procedure (P&P) titled, Food Preferences, (undated), the (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated, Policy: Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group. Condiments such as salt, pepper, and sugar are available at each meal unless contraindicated by the diet order.		

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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 ensure that medical records were complete and accurately documented for one of three sampled residents (Resident 4) when Resident 4's Physician Order for Life-Sustaining Treatment (POLST- a document that contains a persons end of life wishes) form was not signed by Resident 4's current responsible party (RP-an individual who has control over healthcare decisions).This failure had the potential to result in Resident 4's healthcare wishes not being followed.During an interview on [DATE] at 11:38 a.m. with Social Services Director/ Medical Records (SSD/MR) the SSD/MR stated the process of the facility was to review and update the POLST form once a year and as needed. The SSD/MR stated Resident 4's spouse was her RP before 5/2025. The SSD/MR stated, Resident 4's spouse's health status changed, and he was no longer able to make healthcare decisions. The SSD/MR stated Resident 4's RP was currently her son. The SSD/MR stated Resident 4's POLST needed to be updated with the sons' signature as RP.During an interview on [DATE] at 3:29 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the licensed nurse was responsible for ensuring a POLST form was complete. LVN 2 stated a POLST form was not valid if it was not signed by the RP. LVN 2 stated the RP was the residents advocate that was assigned to fulfill end of life wishes. LVN 2 stated the RP was the person responsible for the resident and was the only one to say what life saving measures should be done. LVN 2 stated it was not okay for another family member that is not RP to sign the POLST form. LVN 2 stated if a POLST was signed by someone who was not the RP, something could happen against the residents end of life wishes.During an interview on [DATE] at 10:08 a.m. with the Director of Nursing (DON), the DON stated the POLST needed to be completed and filled out entirely. The DON stated the POLST form should be signed by the RP. The DON stated Resident 4's RP was previously her spouse. The DON stated now Resident 4's son was the current RP. The DON stated if the form was not filled out completely, it was not valid. The DON stated it was important for the correct RP to sign the POLST form to ensure resident decisions and to make changes. The DON stated if transferred from the facility to the, the hospital would follow the POLST instructions. The DON stated Resident 4's wishes may not be carried out the way the resident wanted if the POLST was not signed by the correct RP.During a review of Resident 4's admission Record (AR) dated [DATE], the AR indicated Resident 4 was admitted to the facility on [DATE] with diagnosis of Type 2 Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) with Ketoacidosis (a condition when the body lacks insulin and begins to break down fat as fuel) without coma (a state of prolonged unconsciousness), Huntington's Disease (an inherited disorder that causes nerve cells in the brain to break down and die), and Chronic Obstructive Pulmonary Disease Unspecified (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 4's medical record, Resident 4's POLST dated [DATE], the POLST form indicated, Cardiopulmonary Resuscitation (CPR - emergency treatment when someone's breathing or heartbeat has stopped). check one [box with checkmark Do not attempt resuscitation/DNR (allow natural death) Medical Interventions.Check one [box with checkmark selective treatment-goal of treating medical conditions while avoiding burdensome measures [box with a checkmark] request transfer to hospital only if comfort needs cannot be met in current location. Artificially Administered Nutrition check one [box with a checkmark No artificial means of nutrition. Information and Signatures discussed with: [box with a checkmark] legally recognized decision maker Print Name: [resident's spouse's name] Relationship: POA [Power of Attorney] signature: [signed by spouse] date: [DATE].During a review of the facilities policy and procedure (P&P) titled, Charting and Documentation, dated [DATE], the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to identify and monitor safety and accident hazards (are situations or factors with the potential to cause harm or damage in a workplace) when a personal portable electric heater (is a device that converts electric current into heat) was being used in the Infection Preventionist (IP) room. This failure placed the facility at an increased risk of fire. During a concurrent observation and interview on 9/5/25 at 8:40 a.m. with the Social Services Director (SSD), in SSD/IP's room, a personal portable electric heater was located on the floor at the back of the IP's chair. The IP nurse was not in the room. The SSD stated the personal portable heater belonged to the IP nurse. The SSD stated it was hot in the room. The SSD stated the IP nurse had been using her personal portable heater because she was always cold. During an observation and interview on 9/5/25 at 9:17 a.m. with the Maintenance Supervisor (MTNS), the MTNS went to IP's room, and the personal portable electric heater was on with heat coming out. The MTNS stated he was not aware of the personal space heater in the IP's room. The MTNS stated there was no temperature monitoring of the IP's personal portable electric heater. The MTNS stated the personal portable electric heater should not be allowed in the room except for an emergency. The MTNS stated the personal portable electric heater posed safety risks to the facility and it was a fire hazard. During an observation on 9/5/25 at 10:00 a.m. in the SSD/IP's room, the personal portable space heater was running and was unattended. During an interview on 9/5/25 at 2:10 p.m. with the Interim Administrator (IADM), the IADM stated he had no knowledge of IP's usage of personal portable electric heater in her room. The IADM stated he thought the IP had an air conditioner in the room, and not an electric heater. The IADM stated he will check and find out for the facility's policy for the use of personal electric heater. During an interview on 9/5/25 at 2:56 p.m. with the IADM, the IADM stated the facility had no policy about the use of personal portable electric heater. During an interview on 9/5/25 at 3:30 p.m. with the IP, the IP stated the MTNS was aware of the personal portable electric heater in her room. The IP stated she needed to use a personal portable heater because she was always cold in her room, and stated, I freeze. The IP stated the MTNS instructed her to use a personal portable electric heater. During a review of facility's job description titled, Maintenance Supervisor, undated, the job description indicated, .Responsibilities: The person holding the position is delegated the responsibility for carrying out the assigned duties and responsibilities in accordance with current existing federal and state regulations. During a review of professional reference titled, https://www.nfpa.org/news-blogs-and-articles/blogs/2018/02/16/nfpa-1-requirements-for-portable-electric-heat dated 2/16/18, indicated, The National Fire Protection Association (NFPA) Life Safety Code (NFPA 101) prohibits portable space heaters in all healthcare occupancies, including skilled nursing homes, to prevent fire hazards. However, a limited exception allows for the use of listed, safety-certified electric heaters with self-extinguishing features in non-sleeping staff areas, provided the heating element does not exceed 212 F and they meet strict safety guidelines like constant supervision and placement away from flammable materials. Why Portable Heaters Are Prohibited? Fire Risk: Portable electric heaters are a significant fire risk, with the majority of fires occurring when combustible materials are too close to the heater.		