STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555866	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista Healthcare	1715 South Cedar Fresno, CA 93702

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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 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 store, prepare, distribute and serve food and ice in accordance with professional standards for food service safety when:1. The kitchen ice machine was observed to have several areas with a removable black substance when wiped with a white paper towel and was not sanitized according to manufacturer's directions.2. The kitchen's sanitizer solution was not the appropriate concentration to sanitize the food preparation area.3. A high calorie/protein nutritional supplement drink was observed in station two's refrigerator, open, and with no open date written on the carton. These failures had the potential to cause cross contamination (the process by which germs are unintentionally transferred from one substance or object to another, with harmful effect) and the growth of microorganisms (a microscopic organism, especially a bacterium, virus, or fungus) that harbor foodborne pathogens (a bacterium, virus, or other microorganism that can cause disease) of residents' food and ice which could lead to food-borne illness (stomach illness acquired from ingesting contaminated food) for the 91 residents admitted to the facility.1. During an observation on 1/6/26 at 10:40 a.m. in the kitchen, Dietary Aid (DA) 1 was observed pouring ice from the ice machine into pitchers with water. DA 1 stated the ice in the pitchers was from the ice machine and was used for the carts for the residents.During a concurrent observation and interview on 1/6/26 at 3:40 p.m. with the Dietary Manager (DM) in the kitchen, a paper towel was used to wipe the inside chute of the ice machine. DM was shown the white paper towel used to wipe the ice chute of the kitchen's ice machine, that had a visible black substance on it. DM acknowledged seeing the black substance and stated she would inform maintenance about the findings.During an observation on 1/6/26 at 3:58 p.m., on the nursing station for station one, there was an ice chest filled with ice and on the counter an orange beverage dispenser that showed a sign that stated ice water.During a concurrent interview and record review on 1/7/26 at 8:30 a.m. with Maintenance Assistant (MA), the ice machine's manufacturer instructions titled, Cleaning/Sanitizing Procedure instructions was posted up on the ice machine's door. The instructions indicated, three ounces of sanitizer should be run through the system as part of the cleaning process for a 30 (inch) wide ice machine. MA stated that he was responsible for cleaning the ice machine monthly and last cleaned it on 12/30/25. MA stated that during the cleaning of the ice machine he first ran 5 ounces of the ice machine descaler through the system, then used two ounces per three gallons of water to clean all parts of the ice machine inside and out. MA stated he received training when the ice machine was installed in 2022 and was instructed to use the sanitizer to clean the machine parts inside and out. MA stated he was not instructed to put the sanitizer through the ice machine as part of the cleaning process. MA stated he did not run three ounces of sanitizer through the ice machines system. The ice machine's water curtain was wiped with a white paper towel and a black substance was observed on the white paper towel. MA acknowledged the black substance removed from the ice machine. During an interview on 1/7/26 at 3:50 p.m. with DM, DM stated the only ice machine in the facility was in the kitchen. DM stated ice from the ice machine is used for water pitchers, the nurses station hydration jug, and ice chests. During a review of the facility's monthly ice machine cleaning log titled, [Name of facility] Monthly Ice Machine Cleaning Schedule, (undated), the Monthly Ice (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Machine Cleaning Schedule indicated, Date.12/30/25.Signature for Ice Machine Cleaning. followed by MA signature.During a review of the ice machine manufacturer's directions, titled, Section 4 Maintenance, dated 2/20, the Section 4 Maintenance document indicated, .Step 13.Add the proper amount of ice machine sanitizer to the water trough by pouring between the water curtain and evaporator.During a review of the facility's policy and procedure (P&P) titled, Sanitization, dated October 2008, the Sanitization P&P indicated, .12. Ice machines and ice storage containers will be drained, cleaned and sanitized per manufacturer's instructions.2. During a concurrent observation and interview on 1/7/26 at 10:05 a.m. with Dietary [NAME] (DC) 1 in the kitchen, DC 1 was observed cleaning the stainless-steel food preparation counter after preparing minced and moist (texture) chicken. DC 1 used a towel from the green bucket to wash the counter, then used a clean towel and put it in water from the faucet in the food preparation sink and wiped down the counter. DC 1 then used a towel from the red sanitation bucket containing quaternary ammonium solution to wipe down the food preparation counter. The red bucket's sanitizer solution concentration was tested by DC 1. DC 1 stated the sanitizer concentration was 100 parts per million (ppm-a unit typically used to express the concentration of a substance in a solution or mixture) while holding the test strip up to the manufacturer's directions. DC 1 stated 100 ppm was not okay and the sanitizer concentration needed to be 200 ppm. During a review of the facility's policy and procedure (P&P) titled, Sanitization, dated October 2008, the Sanitization P&P indicated, .4. Sanitizing of environmental surfaces must be performed with one of the following solutions.150-200 ppm quaternary ammonium compound. 3. During a concurrent observation and interview on 1/6/26 at 3:52 p.m. with Licensed Vocational Nurse (LVN) 7 at station two, station two's refrigerator contents were observed. A high calorie/protein nutritional supplement drink was observed in station two's refrigerator, open, half full and undated with no open date written on the carton. LVN 7 stated the high calorie/protein nutritional supplement drinks were good for three days after opening. LVN 7 looked at the carton and stated there was no open date, and she would discard it immediately.During a review of the carton on the facility's high calorie/protein nutritional supplement drink storage and handling directions, the high calorie/protein nutritional supplement drink storage and handling directions indicated, .Refrigerate after opening and use within 3 days.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure nutritional needs of the residents were met when the menus were not followed for three residents (Residents 7, 21, and 55) on a large portion diet when Resident 21 received three ounces of meatloaf (regular portion) instead of four ounces (large portion), Residents 7 and 55 received 4 ounces of meatloaf and should have received 6 ounces during lunch on 1/6/26. These failures had the potential to result in unintended weight loss, weakness, fatigue, or increased fall risk, and decreased quality of life.During a review of the facility's menu titled, Diet Spreadsheet dated Day: 17 - Tuesday [1/6/26], the Diet Spreadsheet indicated, .Large Portion.Lunch. Homestyle Meatloaf.Portion Size 4 oz (ounces). The Diet Spreadsheet indicated for the lunch meal the regular meatloaf portion size was 3 oz., the regular minced and moist meatloaf with thick gravy was a #8 scoop (4 ounces), the regular puree meatloaf was a # 8 scoop.During an observation of the lunch meal service on 1/6/26 at 12:38 p.m. in the kitchen, Resident 7's meal tray was being prepared by Dietary Manager (DM) and Dietary [NAME] (DC) 1. Resident 7 received a #8 scoop (4 oz.) for the minced meatloaf.During an observation of the lunch meal service on 1/6/26 at 12:41 p.m. in the kitchen, Resident 21's meal tray was being prepared by DM and DC 1. Resident 21 received three oz. of meatloaf.During an observation of the lunch meal service on 1/6/26 at 12:45 p.m. in the kitchen, Resident 55's meal tray was being prepared by DM and DC 1. Resident 55 received a #8 scoop for the pureed meatloaf.During a review of Resident 7's Order Summary Report (OSR) dated January 8, 2026, the OSR indicted, .Regular Large Portions diet.Minced and Moist.During a review of Resident 21's Order Summary Report (OSR) dated January 8, 2026, the OSR indicted, .Regular Large Portions diet Regular Texture .During a review of Resident 55's Order Summary Report (OSR) dated January 8, 2026, the OSR indicted, .Regular Large Portions diet Pureed texture .During a concurrent observation and interview on 1/6/26 at 12:48 p.m. with DC 2 in the kitchen, DC 2 weighed Resident 21's meatloaf before placing the tray into the tray cart (enclosed kitchen cart used to transport meal trays to resident rooms). DC 2 stated the meatloaf was 3 oz. but should have been 4 oz. DC 2 checked Residents 7 and 55's plates and meal tickets and stated the meatloaf was already 4 ounces for the large portion, so they do not give a bigger portion for the minced meatloaf or pureed meatloaf. During a concurrent interview and record review on 1/7/26 at 3:00 p.m. with Registered Dietitian (RD), the facility's Dining Service Menu Guide titled, Small Portion/Large Portion . Dining Service Menu Guide. dated 2022 was reviewed. The Dining Service Menu Guide indicated, . Large Portions Diet . Lunch and Supper: Serve 1 1/2 servings of the entree . RD stated large portions for puree and minced and moist should get more than the menu for the regular portion of those diets. RD stated her expectation was that the resident with a puree large portion should have received more of the meatloaf. RD stated the menu guide for large portions stated they would receive 1 1/2 servings for the entree (6 oz). RD stated that if the residents only received the regular size portion of the entree, that was incorrect. RD stated the entree should have been increased to 1 1/2 servings according to the Dining RD menu guide. RD stated her expectation is that kitchen staff follow the menu and adjust for the appropriate diets.During a review of the facility's document from the Dining Service Menu Guide, titled, Small Portion/Large Portion dated 2022, the Dining Service Menu Guide, titled, Small Portion/Large Portion indicated, .Large Portions Diet.Lunch and Supper: Serve 1 1/2 servings of the entree.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for five of 22 sampled residents (Resident 4, 38, 58, 71, and 98) when:1. Resident 98's foley catheter drainage bag (a bag connected to a tube that is inserted into the urinary bladder to collect urine) was lying on the floor in his room. LVN 5 proceeded to enter his room and manipulate his catheter and did not put on a gown as specified by enhanced barrier precaution (EBP- standards in place in healthcare facilities to prevent the spread of infection) standards. This failure had the potential to cross contaminate (transfer of bacteria from one surface or object to another) Resident 98's catheter and LVN 6's clothing and cause them to be affected by and spread multi drug resistant organisms (MDRO-germs that are resistant to multiple antibiotics, making infections difficult to treat).2. Resident 4's nasal cannula (flexible tube with two prongs that fit inside the nostrils), and oxygen tubing (flexible tube connected to an oxygen source) were found wrapped around Resident 4's bed rail.This failure placed Resident 4 at risk for cross-contamination and infection.3. Resident 58 was symptomatic with a dry, intermittent non-productive cough, and suspected of having a transmissible respiratory infection and was not placed on transmission-based precautions pending lab results. This failure resulted in other residents, staff, and visitors being exposed to Influenza A (commonly known as the flu, a respiratory infection with the influenza A virus, spread through droplets) which could lead to an influenza outbreak and result in serious medical issues. 4. Resident 38 and Resident 71's oxygen (O2) nasal cannula (NC a tube that directs oxygen into the nose) was found unbagged on top of the resident's Oxygen concentrator (medical device that helps you breathe better up to 95% pure oxygen.)This failure had the potential to result in the spread of germs and bacteria that could result in infection and illness.Findings: 1.During a review of Resident 98's admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 1/9/26, the AR indicated Resident 98 was admitted with a diagnosis of a urinary tract infection (UTI- an infection that develops in the urinary system) During an observation on 1/6/26 at 11:19 a.m. in Resident 98's room. Resident 98's catheter was on the floor while he was in bed. During a concurrent observation and interview on 1/6/26 at 11:30 a.m. with LVN 5, LVN 5 entered Resident 98's room, which was on EBP precautions, and did not put on a gown, LVN 5 then proceeded to pick up Resident 98's catheter off the ground. LVN 5 stated the catheter should not have been on the ground because there was a possibility that the catheter bag could have become contaminated or dirty. LVN 5 stated because Resident 98 had a catheter, so he was automatically placed on EBP precautions, and she needed to don(put on) both a gown and gloves to prevent cross contamination from occurring. During an interview on 1/9/26 at 9:46 a.m. with the Infection Preventionist (IP), the IP stated anytime a resident had a catheter in place staff needed to don gloves and a gown before they touched or manipulated it. The IP stated LVN's could potentially cross contaminate their scrubs and carry germs on to another resident by not wearing a gown. The IP stated additionally a Resident's foley catheter bag should not have been on the floor, it was the responsibility of the nurses to ensure foley catheter drainage bags were hooked up and away from the floor because the catheter bag could become contaminated with bacteria from the floor and transfer to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 1/9/26 at 10:12 a.m. with the Director of Nursing (DON), The DON stated it was unacceptable for the foley catheter drainage bag to be on the floor. The DON stated staff also needed to do additional rounding to prevent any catheter bags from lying on the floor. The DON stated Resident 98 was already at a higher risk for infection because of the foley catheter he had and staff members should have either hung up the bag off the floor or reported the problem to someone who could take care of it. The DON stated all nurses need to put on a gown and gloves when entering an EBP room and touching a foley catheter, the precautions are there to prevent the spread of infection and nurses needed to abide by those infection control standards. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, dated 9/14, the P&P indicated, . The purpose of this procedure is to prevent catheter-associated urinary tract infections . Use standard precautions when handling or manipulating the drainage system. Be sure the catheter tubing and drainage bag are kept off the floor . During a review of the facility's P&P titled, Enhanced Barrier Precaution, dated 6/20/24, the P&P indicated, . [EBP] – used in conjunction with the standard precautions and expand the use of [personal protective equipment] to donning of gown and gloves during high-contact resident care activities and in situations of expected exposure to blood, body fluids, skin breakdown, or mucous membranes that provide opportunities for transfer of MDROs to staff hands and clothing to reduce transmission . 4. Facility staff shall perform hand hygiene and will don gown and gloves before performing the following high-contact resident care activities . Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator . 2. During a concurrent observation and interview on 1/7/26 at 4:35 p.m. with Certified Nursing Assistant (CNA) 2 in Resident 4's room, Resident 4's oxygen tubing and nasal cannula were observed wrapped around Resident 4's bed rail. CNA 2 stated Resident 4's oxygen tubing should have been put in the plastic bag when not in use and not wrapped around his bedrail. CNA 2 stated putting the oxygen tubing in the plastic bag was to prevent the tubing from getting dirty and causing an infection. CNA 2 stated it was for infection control. During a review of Resident 4's AR, dated 1/8/26, the AR indicated Resident 4 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), acquired absence of right leg (surgical removal of leg) above the knee, heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and end stage renal disease (a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 11/25/25, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 4 was cognitively intact. During an interview on 1/7/26 at 4:58 p.m. with the Registered Nurse (RN), the RN stated Resident 4's (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen tubing should have been put in a bag when not in use to prevent Resident 4 from getting an infection if the oxygen tubing became dirty and Resident 4 used it. The RN stated putting the oxygen tubing in a bag when not in use was for infection control. During an interview on 1/08/26 at 2:37 p.m. with the Director of Staff Development (DSD), the DSD stated resident's oxygen tubing and nasal cannula should not have been wrapped around the resident's bed rail, it should have been placed in a plastic bag when not in use. The DSD stated the oxygen tubing should not have been used if it was wrapped around the bed rail as it was an infection control issue. The DSD stated the oxygen tubing should have been removed and put in the trash and the CNA should have let the nurse know to replace it. The DSD stated there was the potential for cross contamination if the oxygen tubing was used after being wrapped around the resident's bed rail. The DSD stated the tubing could have had bacteria on it and if the resident used the dirty tubing, the bacteria could have gone into the resident's nose and caused an infection. During a review of the facility's P&P titled, Respiratory Therapy – Prevention of Infection, dated 11/15/23, indicated . the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff . keep the oxygen cannulae and tubing used PRN [as needed} in a plastic bag when not in use . 3. During a review of Resident 58's AR, dated 1/8/26, the AR indicated Resident 58 was admitted to the facility on [DATE] with diagnosis of heart failure (heart muscle does not pump blood well), hypertension (high blood pressure) and depression (mood disorder causing persistent sadness). During a review of Resident 58's MDS, dated 10/8/25, the MDS assessment indicated Resident 58's BIMS assessment score was 13 out of 15 which indicated Resident 58 was cognitively intact. During a concurrent observation and interview on 1/6/26 at 2:55 p.m. with Resident 58, in Resident 58's room, Resident 58's room entrance and room was not observed with transmission-based precaution signage (TBP) or protective personal equipment (PPE). Resident 58 was observed wearing a mask with a hacking cough. Resident 58 stated she was not feeling well. Resident 58 stated, I have something you can catch, you need a mask. Resident 58's roommate, Resident 63 stated, .get out she probably has COVID [Coronavirus disease-an infectious disease caused by the SARS-CoV-2 virus, spread through droplets and aerosols]. During an interview on 1/6/26 at 3:00 p.m. with LVN 4, LVN 4 stated Resident 58 had been exhibiting respiratory symptoms, an intermittent non-productive cough, since the morning. LVN 4 stated the provider had been notified and lab tests had been ordered to rule out COVID, Respiratory Syncytial Virus (commonly called, RSV, a virus that affects the respiratory tract, spread through droplets) and Influenza. LVN 4 stated Resident 58 had not been placed on TBP and PPE had not been provided at her room entrance or room for staff or visitors to use. LVN 4 stated Resident 58's lab results for COVID, RSV and Influenza were not back yet. During an interview on 1/6/26 at 3:03 p.m. with the IP, the IP stated Resident 58 had not been placed on TBP and PPE had not been provided for entry to Resident 58's room. The IP stated Resident 58's COVID, RSV and Influenza lab results were not back yet and it could take up to 24 hours to get those results. During an observation on 1/6/26 at 3:08 p.m. in front of Resident 58's room, two facility staff members were observed entering Resident 58's room with no mask, goggles, gown or gloves and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	closed the door to provide care. During a concurrent observation and interview on 1/8/26 at 9:22 a.m. with Housekeeper (HSK) 2, Resident 58's door was open and HSK 2 was observed cleaning Resident 58's floor. Resident 58 had a droplet precaution (infection control measure to prevent transmitting germs via large respiratory droplets when an infected person coughs, sneezes, or talks, requiring healthcare workers and visitors to wear surgical masks) sign posted on her door. The sign indicated everyone needed to cover their eyes, nose and mouth while in the room. HSK 2 was observed not wearing a face shield or goggles to cover her eyes. HSK 2 exited the room after cleaning Resident 58's floor and stated she should have had a face shield or goggles on, per the droplet TBP signage, to cover her eyes and prevent exposure to Resident 58's transmissible infection. HSK 2 stated it was important to follow TBP signage to prevent exposure or transmission to others. HSK 2 stated she relied on TBP signage to indicate if a resident was on precautions and how to protect herself and limit the spread of infections. HSK 2 stated she expected the facility to implement TBP signage for suspected and known residents with transmissible infections for public safety. HSK 2 stated if a resident was suspected of having a transmissible infection, she expected a TBP sign posted on the room door while awaiting lab results to prevent exposures and transmission of infections to other staff, visitors and residents. During a concurrent interview and record review on 1/8/26 at 2:24 with the IP, Resident 58's Medical Record, dated 1/8/26 was reviewed. The IP stated a transmissible infection was anything that could be spread through contact, droplet or airborne transmission, such as COVID, RSV or Influenza. The IP stated she utilized The Centers for Disease Control and Prevention (CDC) guidelines for infection control and prevention standards of practice. The IP stated Resident 58 was first noted to have respiratory symptoms on 1/6/26 at 1:30 p.m. and COVID, RSV, and Influenza labs were ordered. The IP stated Resident 58's rapid COVID test resulted negative on 1/6/26 at 1:35 p.m. The IP stated Resident 58's Influenza A test came back as positive on 1/7/26 at 3:55 p.m. The IP stated Resident 58 was then moved to a private room and TBP droplet precaution signage was initiated and PPE provided outside her room. The IP stated Resident 58's RSV came back as negative on 1/8/26 at 10:21 a.m. The IP stated infection control and prevention standards of practice or facility policy were not implemented when Resident 58 was symptomatic and suspected of having multiple transmissible respiratory infections and TBP precautions were not initiated. The IP stated residents, staff and visitors were placed at risk of acquiring Influenza A which could result in serious medical issues or an outbreak if not contained. The IP stated she expected staff and visitors to adhere to TBP signage and infection control and prevention policy when providing care to prevent the transmission of infections to others. During an interview on 1/9/26 at 9:16 a.m. with the DON, the DON stated she expected the facility to always adhere to infection control and prevention standards of practice and facility policy and procedure. The DON stated the IP was responsible for implementing infection control and prevention policies within the facility. The DON stated Resident 58 should have had TBP signage posted and PPE provided at her room entrance while she was symptomatic and suspected of having a transmissible respiratory infection to ensure all residents, staff and visitors took appropriate precautions to prevent the spread of the potential respiratory infection. The DON stated residents, staff and visitors were placed at risk of transmitting and acquiring Influenza A while Resident 58's lab results were pending. During a review of the facility's P&P titled, Isolation-Category of Transmission-Based Precautions, dated 10/2018, the P&P indicated, .Transmission-Based Precautions are initiated when a resident develops signs and symptoms of a transmissible infection.and is at risk of transmitting the infection to other residents.Transmission-based precautions are additional measures that protect staff, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	visitors, and other resident from becoming infected.when a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for ad the type of precaution.the signage informs the staff of the type of CDC precaution (s), instructions for PPE.droplet precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplet. During a review of the facility's P&P titled, Quality of Life-Dignity, dated 8/2009, the P&P indicated, .in the interest of public health, posting the resident's isolation status or Transmission-Based Precautions is permissible as long as the type of infection remains confidential. During a review of the facility's P&P titled, Influenza, Prevention and Control of Seasonal, dated 8/2014, the P&P indicated, .during periods of increased community influenza activity, rapid screening of residents for symptoms of influenza and separation from other residents during screening may be necessary.droplet precautions will be implemented for residents with suspected or confirmed influenza for seven (7) days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer. During a review of the facility's job duty titled, Infection Control Nurse, dated 2003, the job duty indicated, .ensure the facility is in compliance with current CDC, OSHA, and local regulations concerning infection control or standard/universal precautions. During a professional reference review retrieved from https://www.cdc.gov/infection-control/hcp/viral-respiratory-prevention/index.html titled, Preventing Transmission of Viral Respiratory Pathogens in Healthcare Settings, dated 5/21/25, the professional reference review from CDC indicated,. apply appropriate Transmission-Based Precautions, including placement in a single-person room, when examining a patient with known or suspected respiratory infection. Precautions should be based on the clinical syndrome and the likely etiologic agents (e.g., which respiratory viruses are circulating in the community, contact with someone known to have influenza) and modified once the pathogen is identified or a transmissible infectious etiology is ruled out. 4. During observation of Resident 71 in Resident 71's room on 1/6/26 at 12:43 p.m. O2 NC tubing was seen not in use and not in bag, the tubing was laying on top of the oxygen concentrator. During a review of Resident 71's AR dated 1/7/26, the AR indicated, Resident 71 was initially admitted to the facility on [DATE] with diagnoses of heart failure (severe failure of the heart to function properly,) Atrial Fibrillation ([AFib] is an irregular and often very rapid heart rhythm), and hypertensive heart disease (heart problems that occur because of high blood pressure that is present over a long time). During a review of Resident 71's MDS, dated [DATE], the MDS section C indicated Resident 71 had a Brief Interview for Mental Status (BIMS) score of 3, which suggested Resident 38 had severe cognitive impairment. During a review of Resident 71's Order Summary Report (OSR) dated 1/8/26, the OSR indicated, .Oxygen- At 3 liters (unit of measurement) per/minute via Nasal cannula continuously . During an interview on 1/7/26 at 4:10 p.m. with CNA 2, photos of Resident 71's oxygen tubing were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed not in a bag laying over the oxygen concentrator. CNA 2 stated when tubing is not in use the tubing is placed in a bag to keep clean. CNA 2 stated that nurses and or CNAs can take the NC off the resident and place in the bag, this is done for infection control. CNA 2 further indicated the NC in the photo should not have been left laying over the oxygen concentrator it should have been placed inside a bag for storage until needed. During an interview on 1/7/26 at 4:20 p.m. with DSD, the DSD stated, the NC should not have been laying over the oxygen concentrator and should have been replaced and placed inside a bag when not in use. The DSD stated failure to store respiratory equipment properly could result in contamination and did not align with facility expectation. During an observation of Resident 38 in Resident 38's room on 1/6/26 at 12:36 p.m. O2 NC tubing was seen not in use and not in bag, the tubing was laying on top of the oxygen concentrator. During a review of Resident 38's AR dated 1/7/26, the AR indicated, Resident 38 was initially admitted to the facility on [DATE] with diagnoses of Parkinson's disease with dyskinesia (involuntary, uncontrolled erratic movements) and dementia (a progressive state of decline in mental abilities). During a review of Resident 38's MDS, dated 12/31/25, the MDS section C indicated Resident 38 had a BIMS score of 3, which suggested Resident 38 had severe cognitive impairment. During a review of Resident 38's OSR dated 1/8/26, the OSR indicated, .Oxygen- At 2 liters (unit of measurement) per/minute via Nasal cannula as needed for SOB (shortness of breath) . During an interview on 1/7/26 at 4:10 p.m. with CNA 2, photos of Resident 38's oxygen tubing not in a bag laying over the oxygen concentrator were reviewed. CNA 2 stated when tubing is not in use the tubing is placed in a bag to keep clean. CNA 2 stated that nurses and/ or CNAs can take the NC off the resident and place it in the bag, this is done for infection control. CNA 2 further indicated the NC in the photo should not have been left laying over the oxygen concentrator it should have been placed inside a bag for storage until needed. During an interview on 1/7/26 at 4:20 p.m. with the DSD, the DSD stated, the NC should not have been laying over the oxygen concentrator and should have been replaced and placed inside a bag when not in use. The DSD stated failure to store respiratory equipment properly could result in contamination and did not align with facility expectation. During a review of the facility's P&P titled, Respiratory Therapy-Prevention of Infection, dated 11/15/23, the P&P indicated, .Infection control considerations related to oxygen administration.Keep the oxygen canulae and tubing used PRN in a plastic bag when not in use. During a review of a professional reference from https://www.homecaremag.com/february-2020/dont-let-oxygen-concentrator-lead-infection titled Don't Let an Oxygen Concentrator Lead to Infection, Dated 1/2020, the professional reference indicated, .2 'In Use' Nasal Cannula . For patients switching to portable oxygen or pro re nata home oxygen administration, nasal cannula storage can be problematic. The nasal cannula prongs often become contaminated when patients don't properly protect the cannula between uses (i.e., leaving the nasal cannula on the floor, furniture, bed linens, etc.). Then the patient puts the contaminated nasal cannula back in their nostrils and directly transfers potentially pathogenic organisms from these (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surfaces onto the mucous membranes inside their nasal passages, putting them at risk of developing a respiratory infection. Educate the patient on how to store the nasal cannula between uses in a manner that does not allow it to have direct contact with potentially contaminated surfaces. Either keep the in-use nasal cannula somewhere that does not allow contact with a surface or place it on a clean surface, inside an open clean container, or in an open plastic bag .

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 provide care in a manner that maintained or enhanced a resident's privacy, dignity and respect when two of 12 sampled residents (Resident 95 and 14), foley catheter (an indwelling urinary catheter - a thin tube placed in the bladder to drain urine into a bag) drainage bags were without a dignity cover (a bag used to the cover and hold the urine drainage and collection bag so it was not visible).This failure violated Resident 95 and Resident 14's privacy and had the potential to affect the self-esteem, self-worth, and quality of life of Resident 95 and Resident 14.Findings: During an observation on 1/06/2026 at 9:25 a.m. in Resident 95's room, Resident 95 was observed in bed sleeping, wearing a gown, lying on her left side. A urine bag was observed hanging on the left side of Resident 95's bed, uncovered, on the lower rail. During a review of Resident 95'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 1/8/26, the AR indicated Resident 95 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following a cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting the right, dominant side, type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high) and gastrostomy (the surgical formation of an opening through the abdominal wall into the stomach for nutritional support). During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/24/25, the MDS section C indicated Resident 95 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 95 was severely cognitively impaired. During a concurrent observation and interview on 1/6/2026 at 4:35 p.m. with Certified Nursing Assistant (CNA) 1, in Resident 95's room, Resident 95's urine bag was observed on the lower right side of Resident 95's bed uncovered. CNA 1 stated the CNAs drained and changed resident's urine bags. CNA 1 stated Resident 95's urine bag should have had a cover over the bag to protect Resident 95's privacy and dignity. CNA 1 stated Resident 95 did not need people seeing their urine. CNA 1 stated nurses could have also covered Resident 95's urine bag. During a concurrent observation and interview on 1/06/2026 at 4:39 p.m., with the Registered Nurse (RN), in the hallway outside Resident 95's room, Resident 95's urine bag was observed uncovered on the lower left side of Resident 95's bed. The RN stated Resident 95's bag should have been covered for her privacy. During an interview on 1/08/26 at 2:37 p.m. with the Director of Staff Development (DSD), the DSD stated her expectation was for all residents who had an indwelling urine catheter to have a privacy (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bag on their urine catheter drainage bag to protect the resident's dignity. During an observation on 1/06/2026 at 9:30 a.m. in Resident 14's room, Resident 14 was observed in bed sleeping, wearing a gown, lying on her left side with foam wedges for positioning. A urine bag was observed hanging on the left side of Resident 14's bed, uncovered, on the lower rail. Resident 14 had a second urine bag, uncovered, hanging on the right side of the bed on the upper bedside rail. During a review of Resident 14's AR, dated 1/7/26, the AR indicated Resident 14 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of sepsis (life-threatening blood infection), obstructive and reflux uropathy (when urine cannot drain through the urinary tract. Urine backs up into the kidneys and may cause them to become swollen), and dementia (a progressive state of decline in mental abilities). During a review of Resident 14's MDS, dated [DATE], the MDS section C indicated Resident 14 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 8 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 14 was moderately cognitively impaired. During an interview on 1/7/2026 at 4:10 p.m. with CNA 2, a photo of Resident 14's urine bag was reviewed. CNA 2 stated Resident 14's urine bag should have had a cover over the bag as well as over the nephrostomy urine bag (a tube your healthcare provider places to take pee directly from your kidney and channel it into a bag), to protect Resident 14's privacy and dignity. CNA 2 stated Resident 14 did not need people seeing their urine. During an interview on 1/7/26 at 4:20 p.m. with the DSD, the DSD stated her expectation was for all residents who had an indwelling urine catheter to have a privacy bag on their urine catheter drainage bag to protect the resident's dignity. The DSD further stated the same dignity bag should have been provided for Resident 14's nephrostomy urine bag because it also collected urine. During a review of the facility's policy and procedure (P&P) titled, Quality of Life – Dignity, dated 8/2009, indicated, .each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Residents shall be treated with dignity and respect at all times . [treated with dignity] means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth . staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures . demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: . helping the resident to keep urinary catheter bags covered .

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of seven sampled residents (Resident 96), who self-administered medication, stored their medication safely and securely at bedside when Resident 96 kept nine over the counter medications (OTC) on her bedside table.This failure resulted in Resident 96's OTC medications being accessible to residents, visitors and staff which could result in unauthorized access and unintended use of Resident 96's medication. During a review of Resident 96'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 1/8/26, the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart rhythm), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), anemia (low levels of red blood cells), and hyperlipidemia (high levels of fat in blood).During a review of Resident 96's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/24/25, the MDS section C indicated Resident 96 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 96 was cognitively intact.During a concurrent observation and interview on 1/6/26 at 10:03 a.m. with Resident 96, in Resident 96's room, nine OTC medications were observed on her bedside table. The OTC medications observed were calcium (supplement providing the mineral calcium) 1200 milligram (mg- a unit of measurement for drug dosage), cranberry concentrate with acerola (dietary supplement to support urinary tract health) 36,000 mg per serving, D-Mannose (simple sugar dietary supplement to promote urinary tract health) 2100 mg per serving, GOLO release (dietary supplement to help manage blood sugar, reduce insulin resistance, and support weight loss), hyaluronic acid with methylsulfonylmethane (HA with MSM- dietary supplement supporting joint health)1000 mg, ferrous sulfate (iron supplement) 325 mg, vitamin D3 (dietary supplemental providing vitamin D) 10,000 International Units (IU- a unit of measurement for drug dosage), guaifenesin extended release (thins and loosens mucus in the airway) 1200 mg, and dextromethorphan polistirex extended release (cough suppressant). Resident 96 stated she self-administered her own medication and had always stored her OTC medications on her bedside table.During a concurrent observation and interview on 1/8/26 at 10:43 a.m. with Certified Nursing Assistant (CNA) 4, in Resident 96's room, nine OTC medications were observed on Resident 96's bedside table. The OTC medications observed were calcium 1200 mg, cranberry concentrate with acerola 36,000 mg per serving, D-Mannose 2100 mg per serving, GOLO release, HA with MSM 1000 mg, ferrous sulfate 325 mg, vitamin D3 10,000 IU, guaifenesin extended release 1200 mg, and dextromethorphan polistirex extended release. CNA 4 stated Resident 96 had always stored her OTC medications on her bedside table. CNA 4 stated she would not consider OTC medications stored on a bedside table as safe or secure. CNA 4 stated it was important that all medications were stored safely and securely to prevent unauthorized access and use by other residents, staff or visitors.During a concurrent observation and interview on 1/8/26 at 10:49 a.m. with Licensed Vocational Nurse (LVN) 3, nine OTC medications were observed on Resident 96's bedside table. The OTC medications observed were calcium 1200 mg, cranberry concentrate with acerola 36,000 mg per serving, D-Mannose 2100 mg per serving, GOLO release, HA with MSM 1000 mg, ferrous sulfate 325 mg, vitamin D3 10,000 IU, guaifenesin extended release 1200 mg, and dextromethorphan polistirex extended release. LVN 3 stated Resident 96 self- administered her own medication and had always stored her medication on her bedside table. LVN 3 stated Resident 96 refused to store her medication anywhere other than on her bedside table. LVN 3 stated residents who self-administered (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stored medications at bedside had to undergo Self-Administration of Medication Assessments (SAM). LVN 3 stated the purpose of the SAM was to determine if a resident could safely and reliably take and store their own medications in accordance with facility policy and procedure.During a concurrent interview and record review on 1/8/26 at 10:55 a.m. with LVN 3, Resident 96's Medical Record, dated 1/8/26 was reviewed. LVN 3 stated Resident 96 had a SAM completed on 12/25/25 which indicated Resident 96 verbalized the need for safe storage of medication and agreed to terms and policies for self-administration of medication. LVN 3 stated if Resident 96 could not safely store her medication at bedside and agree to terms and policies for self-administration of medications she would not be an appropriate candidate for self-administration of medication. LVN 3 stated Resident 96 was not safely or securely storing her OTC medications at bedside and was known to refuse safe storage of bedside medication. LVN 3 stated facility policy and procedure were expected to be followed for residents self-administering and storing medications at bedside. LVN 3 stated Resident 96's OTC medications were at risk of unauthorized access and unintended use by other residents, staff or visitors which could result in overdose, allergic reactions or theft.During an interview on 1/9/26 at 8:49 a.m. with the Pharmacist Consultant (PC), the PC stated a SAM was completed to ensure residents stored and self-administered medications at bedside safely and per facility policy. The PC stated if residents were known or observed to be non-compliant storing medications at bedside then they were not an appropriate candidate to keep medication at bedside. The PC stated residents were required to adhere to facility policy and procedure for safe storage of medication at bedside. The PC stated storing nine OTC medications on the bedside table was not safe or secure. The PC stated Resident 96's OTC medications were at risk for unauthorized access and unintended use which could result in overdose, allergic reactions or adverse side effects.During a concurrent observation and interview on 1/9/26 at 9:16 a.m. with the Director of Nursing (DON), Resident 96's bedside table was observed, the DON stated Resident 96 had nine OTC medications stored unsafely on her bedside table. The DON stated Resident 96 was known to be noncompliant with safe storage of self-administration medication at bedside. The DON stated Resident 96 was known to leave her bedside table with medications in the hallway and refuse safe storage of medications at bedside. The DON stated she had documented the non-compliance and education in Resident 96's Progress Notes. The DON stated Resident 96's SAMS were not assessed appropriately if she was known and documented to be noncompliant with safe and secure storage of medication at bedside. The DON stated Resident 96's OTC medications were at risk of being accessed by residents, visitors and staff which could result in unauthorized access and unintended use. The DON stated she expected the facility to uphold policy and procedure for residents storing self-administration medications at bedside.During a review of Resident 96's document titled, Care Plan Report (CP), dated 1/8/26, the CP indicated, date initiated 3/9/24.assess PRN [as needed] to review compliance and continuous ability to self-administer medication(s).During a review of Resident 96's document titled, Progress Note, dated 10/30/25, the Progress Note indicted, .offered resident a medication lock box for her OTC medications that she self-administers. Resident refused and stated that she will just make sure her table is not placed in the hallway anymore when they get her up. Reminder teaching of importance of securing her medications so no other resident has access and she verbalized.During a review of Resident 96's document titled, Self-Administration of Medication, dated 3/8/25, 4/1/25, 9/26/25, 10/13/25 and 12/25/25, the documents indicated, .yes. to .resident can verbalize to staff the need for safe storage of medication. and .resident agrees to terms and policies for self-administration of medication.During a review of the facility's policy and procedures (P&P) titled, Self-Administration of Medications, dated 12/2016, the P&P indicated, .Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so.if the team determines that a resident cannot safely self-administer medications, the nursing staff will administer the resident's medications.self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview, and record review the facility failed to ensure one of six residents (Resident 53) received a level II Pre-admission Screening and Resident Review (PASARR- evaluation for individuals suspected of having a Serious Mental Illness [SMI] or Intellectual/Developmental Disability [I/DD]/Related Condition [RC], triggered by a positive Level I screen, to determine if they need specialized services, ensuring placement in the least restrictive setting) evaluation by the designated entity to determine if SMI, ID/DD/RC conditions were present when Resident 53 had a PASARR level I screening result positive for SMI, and the facility did not ensure a PASARR level II screening was completed.This failure resulted in Resident 53 not receiving the required PASARR level II screening which had the potential to result in missed identification of specialized services needed and put Resident 53 at risk of delayed treatment.Findings:During an observation on 1/06/26 at 12:35 p.m., in the facility dining room, Resident 53 was observed sitting in a wheelchair, dozing off while staff attempted to feed Resident 53 his pureed lunch meal (food that has been ground, pressed, and/or strained to a soft, smooth consistency, like a pudding). Observed staff sitting next to Resident 53 and encouraged Resident 53 to wake up and take a bite of his meal several times. Resident 53 observed closing his eyes after each bite.During a review of Resident 53'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 1/8/26, the AR indicated Resident 53 was admitted to the facility from an acute care hospital on 8/16/21 with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life, repeated falls, major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and post-traumatic stress disorder (a disorder in which a person has difficulty recovering after witnessing or experiencing a terrifying event).During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/4/25, the MDS section C indicated Resident 53 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 53 was severely cognitively impaired.During a review of Resident 53's Department of Healthcare Services (DHCS) letter dated 1/4/22, the letter indicated, . Level I date: 08/16/2021 . unable to complete Level II evaluation. Federal law requires all individuals seeking admission to a Medicaid Certified Nursing Facility (NF) receive a Level I Mental Health Screening. The Level I Mental Health Screening identifies if an individual has a suspected Mental Illness (MI) or an Intellectual/Developmental Disability or Related Condition (ID/DD/RC). If MI is suspected, then a Level II Mental Health Evaluation may be conducted to determine if the individual can benefit from specialized mental health services . after reviewing the Positive Level I Screening and speaking with staff, a Level II Mental Health Evaluation was not scheduled for the following reason: . the individual was isolated as a health or safety precaution. The case is now closed. To reopen, please submit a new Level I Screening . No further documentation was found regarding re-opening Resident 53's case.During a record review of resident 53s Care Plan Report (CP), dated 1/8/26, the CP indicated, . the resident has a behavior problem related to (r/t) dementia, res(ident) Getting out of bed unassisted, and walking around the hallway. Episodes of angry outbursts by throwing items like blanket and care items, hoarding food and drinks, with episodes of trying to get out of the facility sometimes . date initiated: 08/30/2021 . revision on: 10/15/2025 . wander guard applied to the left hand . date initiated 10/25/2024 . risk for wandering or elopement related to exit seeking behavior, frequently asking to go out, dementia, wanders aimlessly . initiated 09/10/2021 . apply wander guard [a device that monitors at-risk residents and protects them from (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista Healthcare	1715 South Cedar Fresno, CA 93702

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elopement or wandering off the facility premises] as ordered . initiated 09/10/2021 . high risk for falls and injury related to poor safety awareness, limitation of mobility, perceived self as independent and will not call for assistance, recent fall in the last 30 days, history of falls(s), use of psychotropic medication(s), . cognitive impairment, dementia . date initiated 08/16/2021 . use of sensor pad alarm when in bed to alert the staff when resident is attempting to get out of bed unattended . date initiated 06/19/2024 . sensor pad alarm on wheelchair . date initiated: 01/05/2026.During an observation on 1/08/2026 at 2:34 p.m. in Resident 53's room, Resident 53 was observed asleep in bed, covered with a sheet. Resident 53's wheelchair observed next to his bed with a sensor pad alarm on the right wheelchair handle. A bed sensor pad alarm noted on Resident 53's left bed rail, and a fall mat observed on the right side of Resident 53's bed. Resident 53 did not respond when knocked on his room door or when spoken to.During an interview on 1/8/2026 at 3:24 p.m. with Resident 53's Responsible Party (RP) 1, RP 1 indicated Resident 53 has had several falls without injury and has had a couple of episodes where he had wandered throughout the facility and expressed a desire to leave the facility. RP 1 stated the facility called her to inform her of each incident and at times she has had to go to the facility or speak with Resident 53 on the phone to put him at ease.During a concurrent interview and record review on 1/08/26 at 10:27 a.m. with the Director of Nursing (DON), Resident 53's letter from the DHCS, dated 1/4/22 was reviewed. The letter indicated, . Level I date: 08/16/2021 . after reviewing the Positive Level I Screening and speaking with staff, a Level II Mental Health Evaluation was not scheduled for the following reason: The individual was isolated as a health or safety precaution. The case is now closed. To reopen, please submit a new Level I Screening . The DON stated a new Level I screening was not scheduled. The DON stated Resident Moore's Level II screening should have been followed up, and a new Level I screening should have been scheduled. The DON stated a PASARR was a screening to see if a resident had a developmental delay or serious mental illness and needed to be placed in a mental health institution. The DON stated the PASARR assessed the accuracy of placing the residents in a Skilled Nursing Facility (SNF) and if the facility was able to meet the resident's needs. The DON stated if the resident screened positive for level 1, HCS requested records and documentation to clear the resident for the SNF. The DON could not verify if a positive PASARR Level II screening for developmental delay or severe mental health indicated if specialized services were needed for the residents. The DON stated Resident 53 should have had a level II evaluation if he triggered a positive level I screening. The DON stated it could be a risk to the resident if there was no level II screening, that a different facility would be more appropriate for addressing the resident's needs if the resident had a severe mental health illness. The DON stated it was a team effort to verify PASARRs were completed and would not give information regarding who was responsible for verifying the PASARRs were complete.During a review of the facility's policy and procedure (P&P) titled, Resident Assessment -Coordination with PASRR Program, dated 10/2025, indicated, . this facility coordinates assessments in accordance with the preadmission screening and Resident review(PASRR) program requirements under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs . applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . Positive Level I Screen - necessitates a PASRR Level II evaluation prior to admission. (cannot be completed by the facility) that determines whether the individual has MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs . if a Resident who was not screened due to an exception above and the Resident remains in the facility longer than 30 days . the facility should screen the individual using the State's Level I screening process and refer any Resident who has or may have MD, ID or a related condition to the appropriate state-designated authority for Level II PASRR evaluation and determination . the Level II Resident review should be completed within 40 calendar days of admission . recommendations, such as any specialized (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services, from a PASRR level II determination and/or PASRR evaluation report will be incorporated into the Resident's assessment, care planning, and transitions of care.During a review of the professional reference titled, Preadmission Screening and Resident Review, dated 2026, retrieved from: https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx, indicated, . the California Department of Health Care Services (DHCS), PASRR Section is responsible for determining if individuals with serious mental illness (SMI) and/or intellectual/developmental disability (ID/DD) or related conditions (RC) require: nursing facility services, considering the least restrictive setting, specialized services. This is achieved by completing the PASRR process. The PASRR process consists of a Level I Screening, Level II Evaluation, and a final Determination.Level I Screening.the Screening is submitted online by the facility and is a tool that helps identify possible SMI and/or ID/DD/RC.If the Screening is positive for possible SMI and/or ID/DD/RC, then a Level II Evaluation will be performed. The Level II Evaluation helps determine placement and specialized services.the SMI Determination will be available online and will include placement and treatment recommendations for the individual.During a review of the professional reference titled, Preadmission Screening and Resident Review, (undated), retrieved from: https://www.medicaid.gov/medicaid/long-term-services-supports/institutional-long-term-care/preadmission-scre indicated, . the PASRR process requires that all applicants to Medicaid-certified nursing facilities be given a preliminary assessment to determine whether they might have SMI or ID. This is called a Level I screen. Those individuals who test positive at Level I are then evaluated in depth, called Level II PASRR. The results of this evaluation result in a determination of need, determination of appropriate setting, and a set of recommendations for services to inform the individual's plan of care.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 (CP - a detailed approach to care customized to an individual resident's needs) for one of six sampled residents (Resident 6), when Resident 6 had a known hernia (a sac protrusion of intestine or other tissue through a weakness or gap in the abdominal wall) and the condition was not addressed in the care plan. This failure placed Resident 6 at risk of experiencing severe and serious medical complications, and had the potential to cause unintentional weight loss, pain, and psychological harm when resident reported discomfort and bloating after eating, and the hernia was not addressed.During a review of Resident 6's admission Record (AR- a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/7/26, the AR indicated, Resident 6 was admitted to the facility on [DATE] with the original admit date of 11/16/21 with a diagnosis of Adult hypertrophic pyloric stenosis (narrowing of the opening between the stomach and the small intestine), Gastrointestinal hemorrhage (bleeding is a sign of a disorder in the digestive tract), Type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), anemia (a condition where the body does not have enough healthy red blood cells), and abdominal hernia.During a concurrent observation and interview on 1/7/26 at 9:30 a.m., with Resident 6, in Resident 6's room. Resident 6 was sitting in bed watching TV, dressed in a t-shirt and blanket partially covered to the abdomen. When Resident 6 was asked about his most recent hospital stay, Resident 6 removed his blanket and stated his stay was because of this, and pointed to a large mass visible through his t-shirt in the middle of his stomach. Resident 6 stated it was a hernia that had been there for years, and the facility knew about it. Resident 6 stated the hernia had caused discomfort after meals. When Resident 6 was asked about the care received to the hernia and the discomfort and pain, Resident 6 stated they tell me they are working on the insurance to pay. Resident 6 stated surgery was scheduled but the insurance had denied it.During a record review of Resident 6's Admission/readmission Screen and Baseline Care Plan, dated 10/22/25, the document indicated, Resident 6 was admitted from a hospital, with the admitting diagnosis of Gastric outlet obstruction. During further review of the document undersection XII. Gastrointestinal (relating to the stomach and the intestines) number four relevant history/comments did not have a notation of the hernia. Continuing to section B. Skin and wound assessment, 2b. other did not have any notes about the hernia.During a record review of Resident 6's Discharge Summary/Order Report (DS), dated 7/28/24, the DS indicated Resident 6 had an Esophagogastroduodenoscopy (EGD- is a diagnostic procedure used to visualize the oropharynx, esophagus, stomach) on 7/26/24 and was found to have a 2 cm (centimeter-a unit of measure) hiatal hernia (occurs when the upper part of the stomach bulges through the diaphragm into the chest cavity).During a record review of Resident 6's Progress notes, dated 12/5/24, indicated acknowledgement of hospitalization July 2024, recent EGD showing a small hernia on June 18th.During a record review of Resident 6's After Visit Summary, dated 11/4/24, the document indicated Resident 6 was seen for abdominal pain and diarrhea, and diagnosis of Ventral hernia without obstruction (Blockage). During a record review of Resident 6's DS, dated 10/22/25, indicated Resident was hospitalized on [DATE], MRI dated 9/29/25 .hernia containing loops of small bowel. Hernia may be causing component of gastric outlet obstruction. During further review of document Resident was discharged from the hospital on [DATE].During Review of Resident 6's Admissions notes, dated 10/22/25, Resident 6 returned to the facility with Diagnosis of abdominal hernia without obstruction.During a concurrent interview and record review on 1/8/26 at 10:28 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated they were not aware of Resident 6's abdominal (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hernia. LVN 5 mentioned Resident 6 had not complained of abdominal pain; otherwise, an assessment would have been carried out. LVN 5 further explained that resident assessments are conducted weekly, the last documented weekly assessment was reviewed and dated 1/4/26, it did not mention the hernia in the skin assessment.During a concurrent interview and record review on 1/8/26 at 11:34 a.m. with the Social Services Director (SSD), Resident 6's Electronic Medical Record (EMR) was reviewed. The SSD acknowledged resident 6 has had this hernia since 10/24. SSD stated Resident 6's insurance had denied surgery and they were working on processing the referral. The SSD stated Resident 6 had a preop (an office visit before having surgery) on 9/16/25, the nurses notes indicated no new orders. The SSD confirmed resident 6 was in the facility until 9/27/25 when Resident 6 was sent to the hospital for a Gastrointestinal bleed (GI- bleeding is a sign of a disorder in the digestive tract). SSD stated the EMR indicated Resident 6 returned on 10/22/25. There was no mention of hernia upon return from hospital.During an interview on 1/8/26 at 3:06 p.m., with the Director of Nursing (DON). The DON stated Resident 6's skin assessment dated [DATE] listed the hernia among a long list of diagnoses; however, the hernia was not reflected as an active condition requiring interventions or monitoring. The DON acknowledged Resident 6 had an active diagnosis and it should be assessed, documented, and included in the care plan with appropriate interventions. The DON further emphasized that the medical records should reflect accurate assessments and monitoring to determine if the condition was worsening.During a concurrent observation and interview on 1/8/26 at 3:06 p.m., the DON visually observed Resident 6 in their room. The DON, upon seeing Resident 6 with their shirt on, remarked, Oh yeah, I see it, referring to the hernia.During a review of the facility's P&P titled, Charting and Documentation, dated 7/2017, the P&P indicated, .documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated 12/2016, the P&P indicated, .The comprehensive, person centered care plan will. Incorporate identified problem areas; . Reflect treatment goals, timetables and objectives in measurable outcomes;. Reflect currently recognized standards of practice for problem areas and conditions. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required comprehensive assessment (MDS). Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure professional standards of practice for one of seven sampled residents (Resident 96) who self-administered medication at bedside when:Resident 96 was self-administering vitamin D3 (dietary supplemental providing vitamin D) 10,000 IU (International Units (IU- a unit of measurement for drug dosage), and guaifenesin extended-release (thins and loosens mucus in the airway) 1200 mg (milligrams- a unit of measurement for drug dosage) at bedside with no order.Resident 96 had an order for ferrous sulfate (iron supplement) 325 mg, but the order did not indicate it could be self-administered at bedside.This failure resulted in Resident 96 self-administering medication without complete, and accurate provider orders which could lead to inadequate monitoring, duplicate therapy and/or adverse effects.During a review of Resident 96'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 96 was admitted to the facility on [DATE] with diagnoses of atrial fibrillation (irregular heart rhythm), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), anemia (low levels of red blood cells), and hyperlipidemia (high levels of fat in blood).During a review of Resident 96'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 96 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 96 was cognitively intact.During a review of Resident 96's Order Summary Report (OSR), dated [DATE], the OSR indicated, Resident 96 did not have an order for vitamin D3 10,000 IU or guaifenesin extended-release 1200 mg. The OSR indicated Resident 96 had an order for ferrous sulfate 325 mg, but the order did not indicate self-administration at bedside.During a concurrent observation and interview on [DATE] at 10:03 a.m. with Resident 96, in Resident 96's room, ferrous sulfate 325 mg, vitamin D3 10,000 IU, and guaifenesin extended release 1200 mg, were observed on Resident 96's bedside table. Resident 96 stated she self-administered and stored her over the counter (OTC) medication at bedside. Resident 96 stated she ordered her OTC medication online and had it delivered to her bedside. Resident 96 stated she self-administered ferrous sulfate 325 mg, vitamin D3 10,000 IU, and guaifenesin extended release 1200 mg at bedside every day.During a concurrent observation and interview on [DATE] at 10:43 a.m. with Certified Nursing Assistant (CNA) 4, in Resident 96's room, ferrous sulfate 325 mg, vitamin D3 10,000 IU, and guaifenesin extended release 1200 mg, were observed on Resident 96's bedside table. CNA 4 stated Resident 96 self-administered and stored her medication at bedside. CNA 4 stated Resident 96 ordered OTC medications online and had them delivered bedside. CNA 4 stated all staff on Resident 96's care team were responsible to inventory and identify new items at bedside, including OTC medications. CNA 4 stated it was important OTC medications were identified and inventoried to ensure OTC medications were accounted for and safe to self-administer. During a concurrent observation and interview on [DATE] at 10:49 a.m. with Licensed Vocational Nurse (LVN) 3, ferrous sulfate 325 mg, vitamin D3 10,000 IU, and guaifenesin extended release 1200 mg, were observed on Resident 96's bedside table.During a concurrent interview and record review on [DATE] at 10:55 a.m. with LVN 3, Resident 96's Medical Record, dated [DATE] was reviewed. LVN 3 stated Resident 96 self-administered and stored her medication at bedside. LVN 3 stated Resident 96 did not have an order for vitamin D3 10,000 IU or guaifenesin extended release 1200 mg. LVN 3 stated all medications being administered required an order. LVN 3 stated without an order it would be unknown by staff Resident 96 was taking vitamin D3 10,000 IU or guaifenesin extended release 1200 mg, which could (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in medication interactions and/or inadequate monitoring. LVN 3 stated Resident 96 had an order for ferrous sulfate 325 mg, but the order did not indicate the medication was for self-administration at bedside. LVN 3 stated all medications being self-administered and stored at bedside needed to be included in the medication order to prevent duplicate therapy. LVN 3 stated Resident 96 was at risk of being administered ferrous sulfate by nursing staff which could result in increased lab levels, constipation, and/or adverse effects. LVN 3 stated nursing staff was responsible to observe Resident 96 self-administer medications per orders and facility policy and procedure.During an interview on [DATE] at 8:49 a.m. with the Pharmacist Consultant (PC), the PC stated nursing staff was responsible for observing Resident 96 self-administer medications and identifying medications not authorized for self-administration at bedside. The PC stated Resident 96 was at risk for vitamin D3 toxicity, which could result in lethargy and feelings of being un-well, self-administering vitamin D3 10,000 IU without an order. The PC stated vitamin D3 10,000 IU was a high dose and required lab monitoring. The PC stated guaifenesin extended release 1200 mg required an order for self-administration at bedside to ensure medication was appropriate for Resident 96. The PC stated guaifenesin extended release 1200 mg could result in adverse effects if administered improperly and without provider oversight, such as renal stones (kidney stones). The PC stated Resident 96 was at risk for duplicate therapy by self-administering ferrous sulfate 325 mg, when the order did not indicate it was for self-administration at bedside, which could result in high blood levels of iron. The PC stated order instructions needed to indicate if medication was being self-administered at bedside to prevent nursing staff from administering the medication.During a concurrent observation and interview on [DATE] at 9:16 a.m. with the Director of Nursing (DON), ferrous sulfate 325 mg, vitamin D3 10,000 IU, and guaifenesin extended release 1200 mg, were observed on Resident 96's bedside table. The DON stated all medications for self-administration required an order and order instructions indicating the medication was for self-administration at bedside. The DON stated nursing staff was responsible for identifying medications at bedside, reporting any new medications at bedside, and observing residents self-administering medications at bedside. The DON stated facility policy and procedure was not followed when Resident 96 self-administered vitamin D3 10,000 IU and guaifenesin extended release 1200 mg at bedside with no order and ferrous sulfate 325 mg with no order instructions to self-administer. The DON stated resident 96 was at risk for inadequate monitoring, adverse side effects and duplicate therapy which could result in a serious medical condition.During a review of the facility's policy and procedure (P&P) titled, Medications Brought to the Facility by the Resident/Family, dated 4/2007, the P&P indicated, .residents and families must report to the nursing staff any medications that they want to bring, or have brought into the facility. if a medication is not otherwise available and/or it is determined to be essential to the resident's life, health, safety, or well-being to be able to take a medication brought in from outside, the Director of Nursing Services and nursing staff, with support of the Attending Physician and Consultant Pharmacist, shall check to ensure that.the medications have been ordered by the resident's Attending Physician, and documented on the physician's order sheet.the contents of each container have been verified by a licensed pharmacist.During a review of the facility's P&P titled, Self -Administration of Medications, dated 12/2016, the P&P indicated, .staff shall identify and give to the Charge Nurse any medications found at the bedside that are not authorized for self-administration, for return to the family or responsible party.the nursing staff will routinely check self-administered medications and will remove expired, discontinued, or recalled medications .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to properly follow procedures for medication disposal when two of four medication carts inspected had denture containers being used as medication waste containers.This failure resulted in improper medication disposal during the medication pass and created the potential for medication diversion due to failure to dispose of medications at the required time.Findings:During a concurrent observation and interview on 1/8/26 at 8:19 a.m. during Licensed Vocational Nurse (LVN) 5's medication pass, LVN 5 dropped a thiamine (a medicine used to protect the brain, nerves, and heart by preventing or treating vitamin deficiency) 100 milligrams (MG- a unit of measurement) tablet and then proceeded to place the dropped tablet in an unlabeled denture container. LVN 5 stated the denture container was used to discard medications during the med pass. LVN 5 stated all tablets, capsules, and liquids were discarded in the denture cup and then placed in the actual medication disposal container at the end of the shift. During a concurrent observation and interview on 1/8/26 at 8:46 a.m. during LVN 5's medication pass, LVN 5 dropped a folic acid (medicine used to help make healthy red blood cells) 1 mg tablet and then proceeded to place the dropped tablet in the denture container. LVN 5 stated the med cart should have contained an appropriate container for disposing medications in order to prevent any diversion and to help nurses dispose of the medicine at the same time the need for disposition was required.During a concurrent observation and interview on 1/8/26 at 4:00 p.m. with LVN 6, the second medication cart in station one was reviewed. The medication cart contained a denture container which was used for disposing medication. LVN 6 stated any medications that needed to be discarded were placed in the denture container. LVN 6 stated she dumps the medications collected in the container in the proper waste receptacle located in the med room at the end of her medication pass. LVN 6 stated if a nurse forgets they had medications in the denture container they could potentially forget to properly discard them at the end of their medication pass. LVN 6 stated medications that needed to be discarded should have been placed in the proper disposal container during the exact time they needed to be discarded, not at the end of the medication pass or at the end of shift. LVN 6 stated improper disposition practices could confuse newer nurses or even lead to someone diverting the medications.During an interview on 1/9/26 at 8:42 a.m. with the Pharmacy Consultant (PC), the PC stated medications should not have been disposed of in denture cups. The PC stated there were proper disposal containers available in sizes that could fit in the medication carts. The PC stated it was important to provide tamper proof medication disposal containers because it helped prevent diversion of medications and it ensured medications were properly disposed of during the exact time they needed to be.During an interview on 1/9/26 at 10:12 a.m. with the Director of Nursing (DON) the DON stated proper disposition of medications should be done in an appropriate container designated for medication disposition. The DON stated medications also needed to be disposed of right at the exact time it was required, not at the end of medication pass or at the end of the shift, this ensured discarded medications were disposed of properly and eliminated any chance for diversion.During a review of the professional reference (PR) retrieved from https://www.epa.gov/system/files/documents/2022-10/10_step_blueprint_guide_final_9-22.pdf titled, A 10-Step Blueprint for Managing Pharmaceutical Waste in US Healthcare Facilities, dated 2022, the PR indicated, , the [medication waste] container must also be secured in a way that prevents unauthorized access to its contents . a healthcare facility can use containers that are designed to prevent access to the contents . Healthcare facilities often require personnel to place, squirt, etc., . controlled substance wastage into a sequestration device. Sequestration devices are containers that are designed to collect liquid and other forms of drug wastage in a way that is highly resistant to diversion . Containers must be labeled with the words Hazardous Waste Pharmaceuticals .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to label medications in accordance with accepted professional principles for one of two nasal spray medications located in station 1's medication cart 1 when the medication fluticasone propionate (nasal spray medicine used in the nose to reduce swelling and irritation) did not have patient identifier information on the bottle.This failure had the potential for cross-contamination (process of transferring germs and bacteria from one area to another) if another resident who was prescribed the same medication received Resident 102's unlabeled fluticasone propionate.Findings:During a review of the Resident 102's Order Summary Report (OSR), the OSR indicated Resident 102 was prescribed fluticasone propionate 50 MCG (Micrograms- a unit of measurement) to be given once a day in each nostril.During a concurrent observation and interview on 1/8/26 at 2:40 p.m. with Licensed Vocational Nurse (LVN) 5, medication cart 1 in nurses station 1 was reviewed. The medication cart had Resident 102's fluticasone propionate nasal per spray bottle unlabeled with a resident identifier. LVN 5 stated the medication was a nasal spray and it worked by inserting the tip of the bottle into Resident 102's nose to deliver the medication. LVN 5 stated Resident 102's name was not on the medication bottle. LVN 5 stated fluticasone was a very common medication and not labeling the bottle could cause confusion among staff if another resident had the same medication. LVN 5 stated the wrong resident could potentially receive another resident's medication. LVN 5 stated properly labeling the bottle also helped reduce the risk of infection because it minimized the chance of residents inserting someone else's medicine into their nose.During an interview on 1/9/26 at 8:42 a.m. with the Pharmacy Consultant (PC), the PC stated the fluticasone propionate bottle needed to have the appropriate resident identifiers to avoid giving the medication to another resident who could be prescribed the same medication. The PC stated the facility could have placed a label on the medication or even written the resident's name on the bottle.During an interview on 1/9/26 at 9:46 a.m. with the Infection Preventionist (IP), the IP stated Resident 102's fluticasone nasal spray should have had a patient identifier on the bottle itself because it was currently flu season and another resident could be prescribed the same medication and accidentally insert the wrong one into their nose and cross contaminate themselves.During an interview on 1/9/26 at 10:12 a.m. with the Director of Nursing (DON), The DON stated the fluticasone propionate bottle and all other similar medications needed to have the patient name on the bottle itself. The DON stated this was done in order to ensure the right med and the right dosage was given to the right patient.During a review of the facility's policy and procedure (P&P) titled, Labeling of medication Containers, dated 4/07, the P&P indicated . all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations . labels for individual drug containers shall include all necessary information such as: a. the resident's name .

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to ensure pureed (food that's been blended into a smooth pudding like consistency) food was prepared in a form designed to meet individual needs for three of five sampled residents (Residents 5, 55, and 84) when Residents 5, 55, and 84's physician ordered pureed lunch meals on 1/6/26 and 1/7/26 did not hold shape or form. This failure had the potential to result in aspiration (food entering the airway or lungs), choking, and inadequate nutrition due to decreased flavor, which may result in weight loss and malnutrition.During a review of the facility's menu titled, Diet Spreadsheet dated Day: 17 - Tuesday [1/6/26], the Diet Spreadsheet indicated, . Pureed . (texture) . lunch pureed homestyle meat loaf, pureed potato gratin with thyme, and pureed steamed spinach .During an observation of the lunch meal service on 1/6/26 at 12:33 p.m. in the kitchen, Resident 5 and Resident 55's puree meat and vegetables were touching and unable to hold their shape or form when plated.During an interview on 1/6/26 at 10:36 a.m. with Dietary [NAME] (DC)1, DC 1 stated she knew if the pureed food looked like pudding it was pureed adequately. DC 1 stated the cooks do not do any type of testing to check for adequacy in the food's consistency.During a review of the facility's menu titled, Diet Spreadsheet dated Day: 18 - Wednesday [1/7/26], the Diet Spreadsheet indicated, . Pureed . (texture) . lunch Italian grilled chicken and vegetable pasta . pureed breadstick .During an observation of the preparation of puree pasta and concurrent interview with Dietary [NAME] (DC) 2 on 1/7/26 at 10:52 a.m., DC 2 stated she will blend mixture until it is lump free and she wants the consistency of the food to be smooth and to hold its shape when plated. During an observation of the lunch meal service on 1/7/26 at 12:12 p.m. in the kitchen, Resident 84's pureed grilled chicken and vegetable pasta all touched, ran into each other, and did not hold form when plated.During a concurrent observation and interview on 1/7/26 at 12:52 p.m. with Dietary Manager (DM) and Corporate Registered Dietitian (CRD) at station two, two sample meal trays (food that is meant to be tasted for adequacy) containing regular prepared food and pureed food were sampled. The pureed Italian Grilled Chicken, Vegetable Pasta, and breadstick served, were observed to be running into each other and not holding their shape or form. DM and CRD stated the pureed food on the sample meal tray was not holding its shape or form. DM stated the current recipes don't state how much liquid or thickener to add to the recipes. DM stated it was important for food to hold its form for appearance and also to hold its temperature.During a concurrent interview and record review on 1/7/26 at 3:50 p.m. with DM, DM stated that when pureed food is plated, they want it to hold its shape and form as is shown in the picture titled, Proper Puree Consistency placed near the kitchen stove on the wall for staff to see. DM stated the pureed foods were too thin. DM stated staff tried to add gel thickener (a substance that makes liquids or semi-liquids thicker without significantly changing their flavor or other properties) but that made the food too glossy and did not thicken it as it should have. DM stated that the pureed food served on the sample meal tray looked more like the one side of the photo that said, Incorrect Consistency.During review of the facility's document titled Proper Puree Consistency (undated), the document indicated, one picture on the left of five different foods which did not hold form and ran into each other. The picture on the right had four different foods that were well formed in a round scoop shape that held their form. The document indicated, Pureed food that is too thin can increase the risk of aspiration and choking. It can also lead to inadequate nutrition due to decreased flavor, which may result in weight loss and malnutrition .During a concurrent observation and interview on 1/7/26 at 3:26 p.m. with Registered Dietitian (RD), RD stated when observing a picture of Resident 84's pureed lunch meal on 1/7/26 at 12:35 p.m. was not the correct consistency and was not holding its form.During a review of Resident 5 admission Records (AR) dated January 8, 2026, the AR indicated, Resident 5 had diagnosis of dysphagia (difficulty swallowing). During a review of Resident 5's Order Summary Report (OSR) dated January 8, 2026, the OSR indicted, . CCHO (Consistent Carbohydrate Diet) /NAS (No added Salt) diet Pureed texture . (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55, AR dated January 8, 2026, the AR indicated, Resident 55 had diagnosis of dysphagia. During a review of Resident 55's OSR dated January 8, 2026, the OSR indicted, . Regular large portions diet Pureed texture . During a review of Resident 84, AR dated January 8, 2026, the AR indicated, Resident 84 had diagnosis of dysphagia. During a review of Resident 84's OSR dated January 8, 2026, the OSR indicted, . NAS (No added Salt) diet Pureed texture . During a review of the facility's Inservice document titled, Class Attendance Roster (CAR), dated 2/7/25, the CAR indicated, .Type of Training.Continuous Improvement.Course Topic(s): IDDSI: Terminology, Proper Puree Texture, Tray Ticket Accuracy .Trainee Name.Trainee signature. CAR included DC 1 and DC 2's names under the Trainee Name and Trainee Signature section of the document. Included in the documents, was the facility's document titled Proper Puree Consistency and a copy of Resident 5's meal tray ticket. There was no documentation of an evaluation of competency after the in-service was given.During a review of the facility's Inservice document titled, Class Attendance Roster (CAR), dated 4/29/25, the CAR indicated, .Type of Training.Continuous Improvement.Course Topic(s): CAHF: Diets and Food Consistencies (video).Trainee Name.Trainee signature. CAR included DC 1 and DC 2's names under the Trainee Name and Trainee Signature section of the document. During a review of the facility's Inservice document titled, California Association of Health Facilities (CAHF).Video 5-Diets and Food Consistencies Quiz., dated 4/29/25, the CAHF.Video 5-Diets and Food Consistencies Quiz was filled out and completed by both DC 1 and DC 2.During a review of the facility's document from the Dining Service Menu Guide, titled, Pureed dated 2022, the Dining Service Menu Guide, titled, Pureed indicated, . process until there is a smooth, pudding-like or smooth mashed potato consistency . Dining Service Menu Guide .

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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. Based on interview and record review, the facility failed to ensure medical records were complete, accurate, readily accessible and systematically organized for two of thirteen sampled residents (Resident 12 and Resident 10) when:1.Resident 12's consent for the use of bedside rails, was not completed, lacking the indication for use, who the consent was discussed with, licensed nurse signature, and dates of consent, were not present in the medical record.This failure had the potential for improper use of bedside rails and potential injury of resident. 2. Resident 10's Informed Consent for the use of Bed Rails, from 8/24/20-11/3/22, could not be located for over 24 hours and had to be retrieved from an off-site location, was not complete or accurate, and was being used for Resident 10's current bed rail order.This failure had the potential to lead to miscommunication among caregivers, inconsistent care delivery, improper use of side rails, and potential injury of resident. 1.During an observation on 1/6/25 at 9:04 a.m. in Resident 12's room, Resident 12 was seen sitting up in bed watching TV, with both upper bed rails up in use. During a review of Resident 12's document titled, OSR dated 1/9/26, the OSR indicated Resident 12 had a bed rail order on 11/6/25, Bilateral (- having or relating to two sides) 1/2 side rails up as an aid to bed mobility, turning and repositioning, and to assist with transfers. During a review of Resident 12's document titled, Informed Consent for the Use of Bed Rail/s (BRC), which was undated, the document failed to list the specific medical or clinical condition that required the use of the bed rails, who the consent was discussed with, the signature of a licensed nurse, and was not dated. The BRC indicated the resident and ordering physicians' signatures were signed but did not provide the necessary dates of signatures. During a concurrent interview and record review on 1/8/26 at 10:28 a.m. with LVN 5, Resident 12's BRC, was reviewed. LVN 5 stated Resident 12's had an active order for bed rails since 11/6/25. LVN 5 stated consents are in the residents' electronic medical records or in the paper chart. LVN 5 stated Resident 12's BRC was not completed, it was missing the reason why the bed rails were needed, who this information was discussed with, a nurse's signature and the dates of when the signature of the resident and physicians was obtained. LVN 5 stated bed rails should not have been initiated until the consent was properly completed. During a concurrent interview and record review on 1/8/26 at 4:50 p.m., in the medical record office, with the MRD, Resident 12's BRC was reviewed. The MRD stated Resident 12's BRC was an incomplete medical record, because it was missing several areas; the indication for use, who this was discussed with, the nurse's signature and dates of when Resident 12 and the ordering physician singed the consent. MRD stated this was not considered complete and bed rails should not have been implemented until this medical record was properly completed. During a review of the facility's P&P titled, Informed Consent, dated 1/2024, the P&P indicated, .when processing a new order.the following must be done.obtain informed consent from resident or responsible party. During a review of the facility's P&P titled, Bed Safety, dated 12/2018, the P&P indicated, .the staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Charting and Documentation, dated 7/2017, the P&P indicated, .documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 2. During a review of Resident 10's document titled, Order Summary Review (OSR), dated 1/8/26, the OSR indicated Resident 10 had a bed rail order from 8/24/20-11/3/22. The OSR indicated Resident 10 had bed rails re-ordered on 11/7/22 and were still in use. During a review of Resident 10's document titled, Informed Consent for the use of Bed Rail/s (BRC), dated 8/19/20, the document indicated a Licensed Vocational Nurse (LVN) signed the consent on 8/19/20 and the provider signed the consent on 8/20/20. The document indicated Resident 10's representative (RP) gave verbal consent on, .8/19/202. The document did not include the entire written year the RP gave verbal consent. The document did not include a check in the box, .legal representative has given permission for the use of bed rail/s . During a concurrent interview and record review on 1/8/26 at 10:34 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 10's Medical Record, dated 1/8/26, was reviewed. LVN 3 stated Resident 10 had an order for bed rails since 11/7/22. LVN 3 could not locate Resident 10's BRC in the electronic or paper chart. LVN 3 stated all consents were expected to be readily accessible for easy reference. LVN 3 stated all new orders for bed rails required consent to ensure risk and benefits were explained to the resident and/or their representative (RP). LVN 3 stated bed rails could cause entrapment which could lead to injury or death. LVN 3 stated Resident 10 was at risk for improper use of side rails without a consent which indicated intended use. During an interview on 1/8/26 at 11:06 a.m. with Medical Records (MR), MR stated she was unable to locate Resident 10's BRC. During an interview on 1/8/26 at 11:10 a.m. with Medical Records Director (MRD), the MRD stated she was unable to locate Resident 10's BRC. The MRD stated bed rails required a new consent for each new order and upon return from hospitalization or discharge to ensure risk and benefits were explained to the resident and/or their RP. The MRD stated Resident 10 had four folders at an offsite storage location. The MRD could not state what documents were at the offsite storage location. The MRD stated it was important that consents were readily accessible and organized to ensure treatment was being implemented as intended by the provider. During a concurrent interview and record review on 1/9/26 at 10:57 a.m. with the MRD, Resident 10's document titled, BRC, dated 8/19/20, was reviewed. The MRD stated she could only locate one BRC in Resident 10's four folders from the offsite storage location. The MRD stated the consent was not complete or accurate as the BRC did not have a complete date to indicate when verbal consent was obtained from Resident 10's RP. The MRD stated the consent was not complete or accurate as the BRC did not indicate by checking the box if Resident 10's RP gave permission to use bed rails. The MRD stated the BRC was not complete or accurate as the BRC was for Resident 10's 8/24/20-11/3/22 bed rail order and not the 11/7/22 bed rail order. The MRD stated Resident 10's BRC should have been re-obtained with the new bed rail order to ensure risks and benefits were explained to the resident and/or their RP. The MRD stated a new BRC was required for all new bed rail orders to ensure the resident and or/their RP were aware of bed rail use. During a concurrent interview and record review on 1/9/26 at 11:29 a.m. with the Director of Nursing (DON), Resident 10's Medical Record, dated 1/9/26, was reviewed. The DON stated Resident 10 had a (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed rail order from 8/24/20-11/3/22. The DON stated Resident 10 's bed rails were re-ordered on 11/7/22 and were still in use. The DON stated Resident 10's BRC was not complete or accurate as it could not be determined what year Resident 10's RP gave verbal consent. The DON stated Resident 10's BRC was not complete or accurate as the box to give permission to use bed rails had not been checked. The DON stated consents were expected to be readily available and accessible for all active treatments and orders that required informed consents. The DON stated she expected the facility to be in compliance with policy and procedure at all times for bed rail use. The DON stated Resident 10 was at risk for improper use of bed rail use which could result in entrapment, injury or death. During a review of the facility's policy and procedures (P&P) titled, Informed Consent, dated 1/2024, the P&P indicated, .when processing a new order.the following must be done.obtain informed consent from resident or responsible party. During a review of the facility's P&P titled, Bed Safety, dated 12/2018, the P&P indicated, .the staff shall obtain consent for the use of side rails from the resident or the resident's legal representative prior to their use. During a review of the facility's P&P titled, Charting and Documentation, dated 7/2017, the P&P indicated, .documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.