

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555924	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2024
NAME OF PROVIDER OR SUPPLIER  Bethel Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE  2280 Dockery Avenue Selma, CA 93662	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>27137</p> <p>Based on interview and record review, the facility failed to ensure the rights of two of three sampled residents (Resident 1 and Resident 2) right to a dignified private and personal space was respected when one facility male employee laid down on the bed with Resident 1 and had taken a nap with her for several minutes; and when Resident 1's roommate, Resident 2, observed this.</p> <p>This failure resulted in the potential for psychosocial harm such as emotional distress for Resident 1 and Resident 2.</p> <p>Findings:</p> <p>During a review of the facility document titled SOC 341/5 Day Report (Report) , dated 11/18/24, the Report indicated, On 11/13/24, [at approximately 4 p.m.] Administrator was notified by [Resident 2] that a male CNA [Certified Nursing Assistant 1] had taken a nap in [Resident 1's] bed with her. An investigation was started immediately by the management team. Resident [1] was interviewed by [Licensed Nurse] and [Social Services Director]. Watched video footage of B-Wing Hall [hall where Resident 1 and 2 resided]. Staff member from B-wing hall interviewed. Confirmed incident was found to be true. [CNA 1] was notified that he is suspended until further notice. The two [other CNAs, CNA 2 and CNA 3] seen going in the room [from video footage] at [2:06 p.m.] were interviewed. One out of two confirmed that [CNA 1] was lying in bed with [Resident 1]. [CNA 1] was interviewed and confirmed the incident did happen. Facility terminated [CNA 1] effective 11/14/24. [Resident 1] is currently on alert charting for psychosocial distress.</p> <p>During a review of a facility letter (Letter ) dated 11/14/24, to CNA 1, the Letter indicated, We regret to inform you that we have come to the decision to terminate your employment with [the facility] effective November 14, 2024. This decision was reached after careful consideration of your violation of resident rights and its impact on [the facility]. As a responsible employer we believe it has become evident that your behavior does not meet the standards and expectations set forth by [the facility]. The letter was written by the Administrator and signed by CNA 1.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of a signed, written statement (Statement 1 ) from CNA 2, dated 11/15/24, Statement 1 indicated she was getting report from the morning shift CNA when, . [CNA 1] followed us into [Resident 1 and 2's shared room] and greeted the resident then we noticed him sitting/laying next to [Resident 1] and I remember saying Ew, [CNA 1] get out leave her alone but he just laughed it off. That is when [CNA 4] and I came out of her room and moved on to the next. [CNA 4] and I were both in the other room for about 10+ minutes.After that time . I then went into [Resident 1's] room again to ask her if she was ready for her shower that's what [sic] I noticed that [CNA 1] was still in there standing by her door, that's when I was like you're still here and he said ' yes but I'm leaving already. Then he walked off and I just asked [Resident 1] if she was ready and she said yes.</p> <p>During a review of a signed, written statement (Statement 2 ) from CNA 3, dated 11/15/24, Statement 2 indicated, On November 13 [2024], around 2:06 [p.m.], I was doing water pass and got to [Resident 1 and Resident 2's shared room] and noticed [CNA 1] sitting on [Resident 1's] bed moving her blanket then laid on [Resident 1] right side. I had said ew [CNA 1] why are you laying there, then proceeded to do the waters and get out of the room. I did not think anything of it at the time. I had thought as soon as I got out he would've as well.</p> <p>During a concurrent record review and interview on 11/15/24, at 8:55 a.m., with the Administrator and the Director of Nursing (DON), recorded facility video surveillance was reviewed. The Administrator stated the recorded video footage was of the B-Wing hallway, from a ceiling-mounted video camera, that recorded activities in the hallway outside Resident 1 and Resident 2's shared room. The Administrator stated there are no video cameras located inside the residents' room. The video footage indicated time and date information; the Administrator stated the date and times were accurate.</p> <p>The video footage dated 11/13/24, at 2:06 p.m., indicated three uniformed staff persons enter Resident 1 and Resident 2's shared room (the room ). The Administrator identified the staff persons as CNA 1, CNA 2, and CNA 4.</p> <p>The video footage dated 11/13/24, at 2:07 p.m., indicated CNA 2 and CNA 4 leaving the room.</p> <p>The video footage dated 11/13/24, at 2:15 p.m., indicated a staff person working with a cart of water pitchers near the room. The Administrator identified the staff person as CNA 3, and at 2:15 p.m., CNA 3 entered the room.</p> <p>The video footage dated 11/13/24, at 2:16 p.m., indicated CNA 1 coming to the room's doorway, and scratched his head. CNA 3 left the room. CNA 1 then went back into the room.</p> <p>The video footage dated 11/13/24, at 2:23 p.m., indicated CNA 2 entering the room, and walked out about a half a minute later. CNA 1 then walked out of the room. The video footage indicated CNA 1 was the only staff in the room for approximately 16 non-consecutive minutes, from 2:07 p.m. to 2:23 p.m.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/15/24, at 9:29 a.m., with the Administrator, the Administrator stated she learned of the incident involving Resident 1 and CNA 1 on 11/13/24 at 4 p.m. The Administrator stated first learned of the incident when Resident 2 had called her on her phone, as Resident 2 had her phone number. The Administrator stated Resident 2 is alert and oriented, and was Resident 1's roommate. The Administrator stated she then went to Resident 2 and spoke with her about the incident. The Administrator stated Resident 2 saw CNA 1 in Resident 1's bed and had asked CNA 1 ' what are you doing in bed with [Resident 1]?' and CNA 1 responded ' napping.</p> <p>During an interview on 11/15/24, at 9:48 a.m., with the Administrator, the Administrator stated she interviewed CNA 1 regarding the incident between him and Resident 1. The Administrator stated CNA 1 told her he was tired and put his head down. The Administrator stated she also interviewed Resident 1 who gestured to the side of her bed and indicated that was where CNA 1 had laid down. The Administrator stated Resident 1 said this made her uncomfortable.</p> <p>During an interview on 11/15/24, at 11:22 a.m., with Resident 2, in her shared room with Resident 1, Resident 2 stated she had been a resident of the facility since 2017. Resident 2 stated she recalled the event occurring on 11/13/24, with CNA 1. Resident 2 knew and recalled the involved staff by their names. Resident 2 stated, There were females putting water in my room. It was [CNA 2 and CNA 4] and [CNA 1] was in here. I saw that [CNA 1] was in [Resident 1's] bed and was under the blankets with her. I don't know if [Resident 1] was asleep but he was asleep. I could see [Resident 1 and CNA 1] in bed. Our divider curtain [separating Resident 1 and Resident 2's beds for privacy] was halfway open so I could see [Resident 1's] bed. I asked [CNA 1] what he was doing in here but he didn't say anything. No staff came in the room while [CNA 1] was lying in the bed. Staff didn't come in until CNA 2 came in at 2:25 p.m. and told him ' are you still here' and he woke up and got out of bed and left. I saw that [Resident 1] was awake but she didn't say anything about [CNA 1] being in the bed. I didn't like that he was in the bed. I've never seen him do that before. I reported this. I called [the Administrator by phone] and I feel she was responsive.</p> <p>During a review of Resident 2's Minimum Data Sheet (MDS, a comprehensive, standardized assessment tool) , dated 10/28/24, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 2 was cognitively intact (having sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the resident's environment).</p> <p>During a concurrent observation and interview on 11/15/24, at 11:32 a.m., with Resident 1, in her shared room with Resident 2, Resident 1 was noted have difficulties with speech. Resident 1 had a picture board with commonly used words and a device that indicated ' yes' or ' no' but did not use them during the interview. During the interview, Resident 1 nodded her head up and down to indicate ' yes', and shook her head and/or hand back and forth to indicate ' no'. Resident 1 was asked if she recalled CNA 1 being in her bed, and Resident 1 pointed to her right side of her bed and indicated ' yes'. Resident 1 was asked if CNA 1 was just under the covers with her and sleeping, Resident 1 indicated ' yes'. Resident 1 was asked if CNA 1 touched her inappropriately, Resident 1 indicated ' no.'</p> <p>During a review of Resident 1's MDS , dated 9/20/24, the MDS indicated at Question C0500 a score of 15 out of a possible 15, which indicated Resident 1 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of Resident 1's Progress Notes (PN) , dated 11/13/24, at 4:27 p.m., the PN indicated, . notified by [Resident 2, Resident 1's roommate] that a male CNA [CNA 1] had taken a nap with her roommate [Resident 1]. [Resident 2] noted that [CNA 1] was sleeping on top of bedding. The PN indicated this event made Resident 2 uncomfortable , and Will continue to monitor and offer emotional support. The PN dated 11/13/24, at 4:27 p.m., indicated, LATE ENTRY . asked resident if a male CNA had taken a nap with resident. In which resident responded YES.Did the CNA touch you in a personal way? In which resident was able to say No . and shock [sic] her head no.</p> <p>During a review of Resident 1's PN dated 11/13/24, at 4:30 p.m., the PN indicated, Resident will be monitored for psychosocial and emotional distress x72 [hours].</p> <p>During a review of Resident 1's PN dated 11/14/24, at 8:41 a.m., the PN indicated, Resident [1] is currently on alert charity [sic] for psychosocial distress. Resident did not display any post-distress Resident slept well through the night. Resident has followed her normal routine. Writer and staff will continue to offer emotional support.</p> <p>During an interview on 11/15/24, at 12:13 p.m., with CNA 2, CNA 2 stated she recalled the incident occurring on 11/13/24 with Resident 1 and CNA 1. CNA 2 stated while in Resident 1's room, she saw CNA 1 enter the room, then CNA 2 left the room. CNA 2 stated about 10 minutes later, she re-entered the room and saw CNA 1 sitting on Resident 1's bed with part of her blanket covering him. CNA 2 stated, I honestly don't know what he was doing in there. I told him: ' Hey, what are you doing? Leave her alone. CNA 2 stated he then left the room. CNA 2 stated, I should have told the nurse about this after he didn't leave during my first visit, but I didn't I should have told the nurse because I thought he was violating her personal space. If I was in [Resident 1's] position, I wouldn't want someone on my bed like that.</p> <p>During an interview on 11/15/24, at 12:30 p.m., with CNA 3, CNA 3 stated she recalled the incident occurring on 11/13/24 with Resident 1 and CNA 1. CNA 3 stated she entered Resident 1's room and saw CNA 1 sitting on Resident 1's bed, holding a blanket. CNA 3 stated, I asked him: ' What are you doing?' He didn't answer. I didn't think much of it. It's not normal behavior. CNA 3 stated seeing CNA 1 on Resident 1's bed wasn't a normal chit-chat, it was different from a normal chit-chat. I don't know how it was different. I should have told someone.</p> <p>During a review of the facility document titled, Resident Rights , dated 1/24, the Resident Rights indicated, Residents of [the facility] are entitled to certain rights and protections designed to ensure their dignity, safety, and well-being. Here are some of the core rights residents have:</p> <p>1.Right to Dignity and Respect [:] Residents have the right to be treated with respect and dignity at all times. They should receive care that promotes their independence, privacy, and personal preferences.</p> <p>4. Right to Freedom from Abuse and Neglect [:] [the facility] is prohibited from subjecting residents to physical, emotional, or verbal abuse, neglect or exploitation. This includes. mistreatment by staff, visitors, or other residents.</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop, implement, and/or maintain an effective training program for all new and existing staff members.</p> <p>27137</p> <p>Based on interview and record review, the facility failed to ensure two of three employees' (CNA 1 and CNA 3) orientation to the facility and education documentation was thorough and completed by the Director of Staff Development (DSD).</p> <p>This failure had the potential for staff education requirements to not be verified by the DSD, enabling poorly trained staff to work in the facility with residents.</p> <p>Findings:</p> <p>During a review of the facility document titled, Job Description - Director of Staff Development (DSD) , dated 1/24, the Job Description indicated, The Director of Staff Development (DSD) plays a key role in creating a positive learning culture within [the facility], overseeing training and continuing education to support the growth and professional development of nursing and support staff. This role ensures that all personnel maintain the required licensure and certifications, comply with facility policies and are well-equipped with the knowledge and skills necessary for providing high-quality resident care. The DSD coordinates with all mandatory training programs, evaluates staff competencies, and implements educational initiatives in line with federal, state, and facility regulations. Education and Training: Develop, implement, and manage comprehensive training programs, including orientation for new hires, ongoing education, and skills enhancement for staff. Compliance and Regulatory Oversight: Maintain accurate records of all training activities, staff competencies, and compliance documentation.</p> <p>During a concurrent record review and interview on 11/15/24, at 10:18 a.m., with the DSD and the Administrator, Certified Nursing Assistant (CNA) 1's education records were reviewed. Among the documents was a single untitled page indicating, Training was provided for the following substance, processes, or procedures:</p> <p>Harassment Video</p> <p>Abuse Prevention Video/Your Legal Duty Post-Test</p> <p>Blood-borne pathogens &amp; PPE Video and Post-Test</p> <p>Choking? What to do?</p> <p>Dementia Training Video (2hrs)</p> <p>Falling Star Program</p> <p>Unusual Occurrences</p> <p>Fire and Disaster</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Disaster Prep</p> <p>The single untitled page contained areas for name of instructor and date; these areas were blank. The DSD stated, That's because I didn't sign it. The DSD then left the interview and record review.</p> <p>During a review of CNA 1's education records, a four-page document titled, Employee Orientation , contained numerous items, including Job Description, Confidentiality of Resident Information, Fire and Safety Regulations and Procedures, Disaster Plan, a CNA's skill check list, and many others. The Employee Orientation contained areas for the employee and a licensed nurse to sign, name of employee, and Date of Orientation Completed. All these areas were blank on all four pages.</p> <p>During a review of CNA 1's education records, a single page document titled, Orientation , indicated, Please initial on each line that applies to your individual orientation. The Orientation document was blank with no employee name, signature, initials indicating completion, or date.</p> <p>During a review of CNA 1's education records, a single, undated document titled, Harassment: Sex, Religion and Beyond Employee Version , indicated, We are committed to providing a workplace free from unlawful discrimination, harassment and retaliation. The harassment training you received today is part of that effort. Please initial by each number and sign it and turn it in at the end of the training. The document was otherwise blank and contained no employee name, no initials, no signature indication completion, and no date.</p> <p>During a concurrent record review and interview on 11/15/24, at 10:24 a.m., with the Administrator, CNA 3's education records were reviewed. Among the documents was a single untitled page, dated 6/30/23, indicating Training was provided for the following substances, processes, or procedures:</p> <ul style="list-style-type: none"> <li>Harassment Video</li> <li>Abuse Prevention Video/Your Legal Duty Post-Test</li> <li>Blood-borne pathogens &amp; PPE Video and Post-Test</li> <li>Choking? What to do?</li> <li>Dementia Training Video (2hrs)</li> <li>Falling Star Program</li> <li>Unusual Occurrences</li> <li>Fire and Disaster</li> <li>Disaster Prep</li> </ul> <p>The single untitled page contained an area for name of instructor , which was blank.</p> <p>(continued on next page)</p>		

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<p>F 0940</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a review of CNA 3's education records, a two-page document titled, Employee Orientation , was reviewed. Page two indicated areas for the employee and a licensed nurse to indicate orientation items such as Facility Organization, Job Description, Daily Routine, Shift Responsibilities, Daily Assignment Sheets, CNA skill checklist and several other items. All were unsigned, with the Date of Orientation Completed left blank. The Administrator verified the findings for CNA 1 and CNA 3.</p> <p>During an interview on 11/15/24, at 11:55 a.m., with the Administrator, the Administrator stated, It is my expectation that in-service [education] for new hires be proctored [supervised by someone, referred to as a proctor, who verifies the identity of the test taker and maintains test integrity] and precepted [a preceptor is an experienced practitioner who provides supervision during clinical practice and facilitates the application of theory to practice] by the DSD.</p>

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<p>F 0942</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents.</p> <p>27137</p> <p>Based on interview and record review, the facility failed to ensure one of three employees ' (Certified Nursing Assistant, or CNA 1) education on Resident ' s Rights was thorough and completed by the Director of Staff Development (DSD).</p> <p>This failure resulted in staff education on Resident Rights to not be completed and verified by the DSD for CNA 1, enabling CNA 1 to be untrained on Resident Rights while working with residents, including Resident 1 [cross-reference with F550].</p> <p>Findings:</p> <p>During a review of the facility document titled, Job Description - Director of Staff Development (DSD), dated 1/24, the Job Description indicated, The Director of Staff Development (DSD) plays a key role in creating a positive learning culture within [the facility], overseeing training and continuing education to support the growth and professional development of nursing and support staff. This role ensures that all personnel maintain the required licensure and certifications, comply with facility policies and are well-equipped with the knowledge and skills necessary for providing high-quality resident care. The DSD coordinates with all mandatory training programs, evaluates staff competencies, and implements educational initiatives in line with federal, state, and facility regulations. Education and Training: Develop, implement, and manage comprehensive training programs, including orientation for new hires, ongoing education, and skills enhancement for staff. Compliance and Regulatory Oversight: Maintain accurate records of all training activities, staff competencies, and compliance documentation.</p> <p>During a concurrent record review and interview on 11/15/24, at 10:18 a.m., with the DSD and the Administrator, Certified Nursing Assistant (CNA) 1 ' s education records were reviewed. The education records indicated CNA 1 was hired at the facility in 2023.</p> <p>During a review of CNA 1 ' s education records, a four-page document titled, Employee Orientation, indicated numerous items, including I have been instructed in and understand Resident Rights. This item contained an area for CNA 1 to sign the item; it was blank with no signature. The Employee Orientation document indicated other areas for the employee and a licensed nurse to sign, name of employee, and Date of Orientation Completed. All these areas were blank on all four pages. The DSD stated, That ' s because I didn ' t sign it. The DSD then left the interview and record review.</p> <p>During a review of a facility letter (Letter) dated 11/14/24, to CNA 1, the Letter indicated, We regret to inform you that we have come to the decision to terminate your employment with [the facility] effective November 14, 2024. This decision was reached after careful consideration of your violation of resident rights and its impact on [the facility]. As a responsible employer we believe it has become evident that your behavior does not meet the standards and expectations set forth by [the facility]. The letter was written by the Administrator and signed by CNA 1.</p> <p>(continued on next page)</p>		

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