STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555924	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	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)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 During observation, interview, and record review the facility failed to ensure privacy and confidentiality for two out of four residents (Resident 10 and Resident 15) during medication administration and medical treatment when: 1. Resident 10's curtains were not pulled during blood glucose testing (a measurement of the amount of sugar in a person's blood. It involves a finger prick or blood draw from the vein) and administration of insulin (a medication that lowers the amount of sugar in the blood). 2. Resident 15's curtains were not pulled during the administration of eye drops. These failures had the potential to place Resident 10 and Resident 15 at risk of losing their privacy and confidentiality during their medical treatments, and not attaining, or maintaining physical, mental, and psychosocial well-being. Findings: 1. During a concurrent observation and interview on 10/23/24 at 11:16 a.m. with Licensed Vocational Nurse (LVN) 2, in Resident 10's room, Resident 10 was observed dressed, sitting in his wheelchair in the middle of his room, in view of the open doorway. LVN 2 was observed performing a finger stick to check Resident 10's blood glucose. LVN 2 proceeded to lift Resident 10's shirt, exposing his abdomen and administered Resident 10's medication by injection into his abdomen. LVN 2 did not close the door to Resident 10's room or draw Resident 10's curtains for privacy during Resident 10's treatment. LVN 2 stated Resident 10's curtain should have been drawn when administering medications and treatment. LVN 2 stated Resident 10 should have been given privacy during his treatment. LVN 2 stated someone could have walked by and seen Resident 10 getting his finger stick and injection. (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

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 10/28/2024
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10'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 10/24/24, the AR indicated, Resident 10 was admitted on [DATE] with diagnoses of 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), personal history of transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), Type 2 Diabetes Mellitus (a condition where the blood sugar levels in the body are too high), difficulty in walking and polyneuropathy (damage to the nerves that can cause decreased ability to move and feel [sensation]). During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/14/24, the MDS section C indicated Resident 10 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 10 was cognitively intact. 2. During a concurrent observation and interview on 10/23/24 at 7:32 a.m. with LVN 2, in Resident 15's room, Resident 15 was observed dressed, sitting in her wheelchair in the hallway. LVN 2 was observed moving Resident 15 into her room, with Resident 15's roommate. LVN 2 was observed administering Resident 15's eye drops into both eyes of Resident 15. LVN 2 did not pull Resident 15's curtain. Resident 15's roommate was observed sitting in her wheelchair watching the administration of Resident 15's eye drops. LVN 2 stated Resident 15's curtain should have been drawn to provide privacy during Resident 15's medication administration. During a review of Resident 15's AR, dated 10/24/24, the AR indicated , Resident 15 was admitted on [DATE] with diagnoses of heart failure, epilepsy (a seizure [a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness] disorder), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 15's MDS dated [DATE], the MDS section C indicated Resident 15 had a BIMS score of three, which suggested Resident 15 had severe cognitive impairment. During an interview on 10/24/24 at 3:04 p.m. with LVN 3, LVN 3 stated nurses should pull resident's curtain for medication administration. LVN 3 stated pulling the resident's curtain was important to provide resident privacy, HIPPA (Health, Insurance, Portability and Accountability act - a federal law to protect health information) protection, and resident dignity. LVN 3 stated the curtain should have been pulled when residents received medication or care. During an interview on 10/25/24 at 3:32 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated it was important to pull resident's curtains when providing patient care to give the residents privacy. CNA 4 stated the facility provided training on patient privacy, resident rights, and neglect approximately every three months. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Bethel Lutheran Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2280 Dockery Avenue Selma, CA 93662	

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/28/24 at 1:49 p.m. with the Director of Nursing (DON), the DON stated resident privacy was very important during resident care. The DON stated all residents deserved privacy. The DON stated if residents did not receive privacy during care, it could harm residents emotionally. The DON stated it didn't matter which resident, or if the resident had dementia, all residents deserved privacy during their care and treatments. During a review of the facility's job description document titled, Licensed Vocational Nurse (LVN), dated 3/2024, indicated, . key responsibilities . adhere to all state regulations, facility policies, and industry standards related to resident care . compassionate and patient-centered approach to resident care . During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2/2021, indicated, . employees shall treat all residents with kindness, respect, and dignity . federal and state laws guarantee certain basic right to all residents of this facility. These rights include the resident's right to . privacy and confidentiality .

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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** 47888 Based on interview and record review, the facility failed to implement a care plan in regard to pain for one of one residents (Resident 3), when staff did not pre-medicate Resident 3 with an analgesic (a medication that reduces pain) prior to physical therapy. This failure to not follow the care plan, resulted in Resident 3 to have unmanaged pain. Findings: During a review of Resident 3's Face Sheet (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), the face sheet indicated, Resident 3 was admitted to the facility on [DATE] with a diagnosis which included Generalized Abdominal Pain (pain that affects more than half of the abdomen), Poly-osteoarthritis (arthritis that affects five or more joints at the same time), Muscle Weakness (loss of muscle strength) and Contracture of Muscles (bilateral [both sides of body] lower legs- a permanent tightening of the muscles, tendons, skin, or nearby tissues that limits the range of movement of a joint or body part). During a concurrent observation and interview on 10/22/24 at 11:10 a.m., with Resident 3 in his room, Resident 3 was lying in his bed, semi-reclined watching television and laughing. Resident 3 stated he could not walk at all and both of his feet point inward (in towards each other) due to contractures. Resident 3 stated he was in pain due to those contractures and multiple back issues. Resident 3 stated he was in the most pain during transfers in a Hoyer lift (a mechanical device that helps move a person from one place to another with minimal physical effort) from his bed to wheelchair and wheelchair to bed, which he has to do before and after physical therapy (PT). Resident 3 stated PT was also painful because he needed to get up on his feet and that was difficult due to the contractures. Resident 3 stated pain was present when staff would clean him after a bowel movement as well. Resident 3 stated he told staff he was in pain on a daily basis. Resident 3 stated his goal was to be free from pain. During a review of Resident 3's Care Plan (CP), dated 8/30/21, the CP indicated, .Focus: The resident has chronic pain related to past trauma to abdomen, history of partial intestinal obstruction and current use of abdominal pain pump. Resident has longstanding history of chronic, intractable progressive, degenerative lumbosacral spine pain . Goal: The resident will display a decrease in behaviors of inadequate pain control (irritability, agitation, restlessness) . Interventions: Administer PRN (as needed) analgesia as per orders. Give 1/2 hour before treatments of care. Date initiated: 8/30/21 . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's CT (computed tomography- a medical imaging procedure that uses X-rays and a computer to create detailed pictures of the inside of the body) Spine Lumbar (CT- lower back) dated 3/15/23, the CT indicated, .Reason for exam: Lumbosacral disc herniation (slipped or ruptured disc). Chronic lower back pain . Impression: . 2. Loss of the normal lumbar lordosis (a type of spinal curve in which the normal inward curve of the lower back is exaggerated), which can be seen in the setting of muscle spasm. 3. Generalized osteopenia (loss of bone density). 4. There is a spinal stimulator (a medical device that treats chronic pain by sending mild electrical impulses to the spinal cord) . 5. There are disc bulges with facet hypertrophy (a common condition that occurs when the facet joints in the spine enlarge, which can cause pain, stiffness, and reduced range of motion) . During a review of Resident 3's Medication Administration Record (MAR) dated October 2024, the MAR indicated, .Acetaminophen (pain relieving medication) Oral Tablet 325 mg (milligram- unit of measurement) Give 2 tablets by mouth every 6 hours as needed for mild-moderate pain . Start date: 7/28/23 at 10 a.m., . (Administered three times in October) Pain level: 4, PRN: Saturday 10/5/24 at 9:27 p.m., Effective . Pain level: 6, PRN: Thursday 10/24/24 at 11:48 a.m., Effective . Pain level: 4, PRN: 10/24/24 at 8:57 p.m., Effective . During a concurrent interview and record review on 10/25/24 at 10:02 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 3's CP dated 8/30/21 was reviewed. The CP indicated, chronic pain was present for Resident 3 with an analgesic to be given thirty minutes prior to treatment. LVN 1 stated she was the nurse for Resident 3 three days a week. LVN 1 stated care plans are important because they give directions on what to do for the resident on a daily basis. LVN 1 stated she would consider PT to be a treatment and Resident 3 went to PT during her shift. LVN 1 stated she had never administered a PRN analgesic prior to the Resident going to PT and had never seen that portion of the CP before. LVN 1 stated it would be important to administer the pain medication thirty minutes prior so Resident 3 could have been pain free during PT. LVN 1 stated the pain medication would have allowed Resident 3 to participate more because he would be able to move better without pain. LVN 1 stated she should have been addressing Resident 3's pain per the CP and she was not. During an interview on 10/25/24 at 10:30 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 3 always said he was in pain and everything hurts him. CNA 5 stated she reported Resident 3's pain to the nurse. During an interview on 10/25/24 at 11 a.m., with the MDS (Minimum Data Set- a resident assessment tool used to identify resident cognitive and physical function) Nurse Coordinator (MDSN), the MDSN stated she made the CP for Resident 3 and reviewed them quarterly (every 3 months). The MDSN stated CP's drive the daily care for the resident. The MDSN stated the expectation was for nursing staff to have given medication per the CP. The MDSN stated Resident 3 could have a difficult time participating in PT due to his pain not addressed. The MDSN stated Resident 3 deserved to be free from pain and have the CP followed. The MDSN stated the CP for Resident 3 was not followed and should have been. The MDSN stated Resident 3 did not get proper care and his condition could get worse because of it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 11:36 a.m., with the PT assistant, the PT assistant stated Resident 3 did complain about pain during the Hoyer lift transfer and it would be important to premedicate the resident prior to PT. The PT assistant stated Resident 3 went to PT three times a week since June 2024 for his contractures and overall mobility. The PT assistant stated pain needed to be controlled to get the best results during PT. The PT assistant stated that PT would classify as a treatment. During an interview on 10/25/24 at 3:04 p.m., with the Director of Nursing (DON), the DON stated CP's are there to guide the care a resident should have received. The DON stated all staff should know and follow the CP's for Resident 3 like they are written. The DON stated the CP was not followed and Resident 3 could get worse overall. During an interview on 10/28/24 at 10:05 a.m., with LVN 2, LVN 2 stated CP's identify what care needs to be done for the resident and they promote their safety. LVN 2 stated the CP for Resident 3 was not followed because of a miscommunication. LVN 2 stated staff failed to provide pain management for Resident 3 before his therapy. LVN 2 stated Resident 3 deserved to be free from pain and he was not, per the CP. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives (a goal that could be tracked and evaluated over time) and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, including: . e. reflects currently recognized standards of practice for problem areas and conditions . 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, care consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 10. interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 48424 Based on observation interview and record review the facility failed to provide services that met professional standards of quality of care for one of six sampled residents (Resident 3) when Resident 3's Hoyer lift sling (a mobile device which helps caregivers safely transfer patients) was used incorrectly during a transfer from his wheelchair to the bed. This failure caused Resident 3 to experience pain and discomfort and had the potential to result in injury as a result of using the lift improperly. Findings: During a review of Resident 3's Admission Record (AR- a document which provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 10/25/2024, the AR indicated Resident 3 was admitted with the following conditions: contracture of muscles (stiffness or tightening of the muscles which causes inability to move), generalized weakness (overall lack of strength), and generalized abdominal pain (pain in the stomach area). During an observation on 10/23/24 at 11:46 a.m. in Resident 3's room, Certified Nursing Assistants (CNA) 1 and 2 used a Hoyer lift to transfer Resident 3 out of his wheelchair and into his bed. CNAs 1 and 2 positioned the Hoyer lift sling with the shortest hooks attached near Resident 3's shoulders and the longest hooks attached near his legs causing him to be lifted in a sitting position. Resident 3 told CNAs 1 and 2 he was uncomfortable and felt pain during the lift. During an interview on 10/23/24 at 11:58 a.m. with Resident 3, Resident 3 stated he felt uncomfortable when CNAs 1 and 2 were lifting him with the Hoyer lift. Resident 3 stated the way they lifted him put pressure on his lower back and caused pain and discomfort. Resident 3 stated he had had back surgery in the past which made sitting for a prolonged period of time uncomfortable. Resident 3 stated he felt a lot of pressure on his lower back as they were lifting him and placing him on the bed because he was transferred sitting up instead of reclined. During an interview on 10/23/24 at 12:08 p.m. with CNA 1, CNA 1 stated Resident 3 had complained of discomfort during lifts in the past. CNA 1 stated she attached the sling with the longer hooks towards his legs and the shorter hooks towards his shoulders in order to have him sitting upright when transferring from his chair to the bed. CNA 1 stated staff had routinely used this technique and she was unsure if this method was incorrect, as other staff had not provided any correction. During an interview on 10/25/24 at 11:10 a.m. with the director of staff development (DSD), the DSD stated CNAs got trained on how to properly attach the Hoyer lift sling using educational videos. The DSD stated if staff were transferring a resident from a chair to bed, they should have had him in a more reclined position because if they transferred him using a sitting up position, they would need to support his back, so he did not fall. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/25/24 at 2:46 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated staff were supposed to hook the Hoyer lift sling on properly. LVN 6 stated if a transfer from bed to chair was occurring the resident needed to be sitting upright in the sitting position and if a transfer from chair to bed was occurring then the sling needed to be in a more reclined position. LVN 6 stated it was important to use the Hoyer lift and sling properly because improper use could result in injury to Resident 3. During a concurrent interview and record review on 10/28/24 at 10:06 a.m. with LVN 2, the Hoyer lift's, Owner's Manual and Instruction Guide, undated, was reviewed. The Owner's Manual and Instruction Guide indicated when lifting a resident from bed to chair the sling should be positioned so the resident is lifted in a sitting up position, when transferring from chair to bed the position should be reversed in order to have the resident in a reclined position. LVN 2 stated the Owner's Manual and Instruction Guide were not followed for proper use of the Hoyer lift and sling. LVN 2 stated when transferring a resident from the bed to chair the Hoyer lift slings hooks should have been attached with the longer hooks on the bottom part towards the legs and the shortest hooks on the top towards the shoulders and the set up should have been reversed when transferring from chair to bed. LVN 2 stated improper use of the Hoyer lift when transferring a resident could have caused Resident 3 to feel unsafe, sustain an injury, and feel pain. During an interview on 10/28/24 at 11:27 a.m. with the Director of Nursing (DON) the DON stated Resident 3 should not have experienced discomfort during a Hoyer lift transfer. The DON stated staff should have followed the manufacturer guidelines for use of the Hoyer lift in order to use it properly. During a professional reference review, retrieved from https://www.hlshealthcare.com.au/patient-lifting-slings-which-loop-is-which/ titled, Patient Lifting Slings: which loop is which?, undated, indicated, .If a client is returning to bed . the best option would be the longer loops at the back that will lead them to leaning back in the sling. This ensures a smooth transition as the hoist strap is lowered, as the client only has a short journey down to their final position on the pillow. If the carer incorrectly chose the shorter loops, the client would be sitting fully upright in the bed and would then recline down onto the pillow. some clients have described this as a 'free falling' feeling so it makes for a much smoother transfer if the begin the process leaning back . 49949 DO NOT CITE

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47888 Based on observation, interview and record review, the facility failed to ensure the right to be free from pain for one of one residents (Resident 3), when Resident 3 was not given analgesia (pain medication), per his care plan, before physical therapy. This failure resulted in Resident 3 experiencing pain during a transfer from his wheelchair to his bed and during physical therapy. Findings: During a review of Resident 3's Face Sheet (a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the face sheet indicated, Resident 3 was admitted to the facility on [DATE] with a diagnosis which included Generalized Abdominal Pain (pain that affects more than half of the abdomen), Poly-osteoarthritis (arthritis that affects five or more joints at the same time), Muscle Weakness (loss of muscle strength) and Contracture of Muscles (bilateral [both sides of body] lower legs- a permanent tightening of the muscles, tendons, skin, or nearby tissues that limits the range of movement of a joint or body part). During a concurrent observation and interview on 10/22/24 at 11:10 a.m., with Resident 3 in his room, Resident 3 was lying in his bed, semi-reclined watching television and laughing. Resident 3 stated he could not walk at all and both of his feet point inward (in towards each other) due to contractures. Resident 3 stated he was in pain due to those contractures and multiple back issues. Resident 3 stated he was in the most pain during transfers in a Hoyer lift (a mechanical device that helps move a person from one place to another with minimal physical effort) from his bed to wheelchair and wheelchair to bed, which he has to do before and after Physical Therapy (PT). Resident 3 stated PT was also painful because he needed to get up on his feet and that was difficult due to the contractures. Resident 3 stated pain was present when staff would clean him after a bowel movement as well. Resident 3 stated he told staff he was in pain on a daily basis. Resident 3 stated his goal was to be free from pain. During an observation on 10/23/24 at 11 a.m., in the PT room, Resident 3 had facial grimaces while going from sitting to standing with the PT aide. During an observation and interview on 10/23/24 at 11:46 a.m., with Resident 3 in his room, Resident 3 was getting lifted back in bed by two Certified Nurse Assistants (CNA 1 and CNA 2) with the use of a Hoyer lift. Resident 3 was groaning and grimacing while in the lift. Resident 3 stated he was having pain in his back while staff was lowering him in the lift back into bed. Resident 3 stated staff did a good job but was still in a little pain. Resident 3 stated he received pain medication in my stomach but it isn't enough because I hurt sometimes. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 3's Care Plan (CP), dated 8/30/21, the CP indicated, .Focus: The resident has chronic pain related to past trauma to abdomen, history of partial intestinal obstruction and current use of abdominal pain pump. Resident has longstanding history of chronic, intractable progressive, degenerative lumbosacral spine pain . Goal: The resident will display a decrease in behaviors of inadequate pain control (irritability, agitation, restlessness) . Interventions: Administer PRN (as needed) analgesia as per orders. Give 1/2 hour before treatments of care. Date initiated: 8/30/21 . During a review of Resident 3's CT (computed tomography- a medical imaging procedure that uses X-rays and a computer to create detailed pictures of the inside of the body) Spine Lumbar (CT- lower back) dated 3/15/23, the CT indicated, .Reason for exam: Lumbosacral disc herniation (slipped or ruptured disc). Chronic lower back pain . Impression: . 2. Loss of the normal lumbar lordosis (a type of spinal curve in which the normal inward curve of the lower back is exaggerated), which can be seen in the setting of muscle spasm. 3. Generalized osteopenia (loss of bone density). 4. There is a spinal stimulator (a medical device that treats chronic pain by sending mild electrical impulses to the spinal cord) . 5. There are disc bulges with facet hypertrophy (a common condition that occurs when the facet joints in the spine enlarge, which can cause pain, stiffness, and reduced range of motion) . During a review of Resident 3's Medication Administration Record (MAR) dated October 2024, the MAR indicated, .Resident has Morphine (pain relieving medication for moderate to severe pain) 0.1 mg (milligram-unit of measurement)/ml (milliliter- unit of measurement) and Baclofen (muscle relaxing medication) 5.0 mcg (micrograms- unit of measurement)/ml pump to abdomen continuous infusion as follows: Morphine 0.00250 mg/hr (hour) and Baclofen 0.1249 mcg/hr. Monitor every shift for signs/symptoms of complications: respiratory depression, urinary hesitancy and retention, constipation and nausea and vomiting. If noted notify MD (Medical Doctor). Start date: 9/18/23 (administered every day throughout the day) .Acetaminophen (pain relieving medication) Oral Tablet 325 mg. Give 2 tablets by mouth every 6 hours as needed (PRN) for mild-moderate pain . Start date: 7/28/23 at 10 a.m., . (Administered three times in October) Pain level: 4, PRN: Saturday 10/5/24 at 9:27 p.m., Effective . Pain level: 6, PRN: Thursday 10/24/24 at 11:48 a.m., Effective . Pain level: 4, PRN: 10/24/24 at 8:57 p.m., Effective . During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) Section J, dated 10/14/24, the MDS indicated, .B. Received PRN pain medications or was offered and declined? No. Pain Presence: Ask resident: Have you had pain or hurting at any time in the last 5 days? Yes. Pain Frequency: Ask resident: How much of the time have you experienced pain in hurting in the last 5 days? Frequently . During a concurrent interview and record review on 10/25/24 at 10:02 a.m., with Licensed Vocational Nurse (LVN) 1, Resident 3's CP dated 8/30/21 was reviewed. The CP indicated, chronic pain was present for Resident 3 with an analgesic to be given thirty minutes prior to treatment. LVN 1 stated she was the nurse for Resident 3 three days a week. LVN 1 stated care plans are important because they give directions on what to do for the resident on a daily basis. LVN 1 stated she would consider PT to be a treatment and Resident 3 went to PT during her shift. LVN 1 stated she had never administered a PRN analgesic prior to the Resident going to PT and had never seen that portion of the CP before. LVN 1 stated it would be important to administer the pain medication thirty minutes prior so Resident 3 could have been pain free during PT. LVN 1 stated the pain medication would have allowed Resident 3 to participate more because he would be able to move better without pain. LVN 1 stated she should have been addressing Resident 3's pain per the CP and she was not. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 10:30 a.m., with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 3 always said he was in pain and everything hurts him. CNA 5 stated she reported Resident 3's pain to the nurse. During an interview on 10/25/24 at 11 a.m., with the MDS Nurse Coordinator (MDSN), the MDSN stated she made the CP for Resident 3 and reviewed them quarterly (every 3 months). The MDSN stated CP's drive the daily care for the resident. The MDSN stated the expectation was for nursing staff to have given medication per the CP. The MDSN stated Resident 3 could have a difficult time participating in PT due to his pain not being addressed. The MDSN stated Resident 3 deserved to be free from pain and have the CP followed. The MDSN stated the CP for Resident 3 was not followed and should have been. The MDSN stated Resident 3 did not get proper care and his condition could get worse because of it. During an interview on 10/25/24 at 11:36 a.m., with the PT assistant, the PT assistant stated Resident 3 did complain about pain during the Hoyer lift transfer and it would be important to premedicate the resident prior to PT. The PT assistant stated Resident 3 went to PT three times a week since June 2024 for his contractures and overall mobility. The PT assistant stated pain needed to be controlled to get the best results during PT. The PT assistant stated that PT would classify as a treatment. During an interview on 10/25/24 at 3:04 p.m., with the Director of Nursing (DON), the DON stated CP's are there to guide the care a resident should have received. The DON stated that of course the Hoyer lift was uncomfortable for him given his condition. The DON stated all staff should know and follow the CP's for Resident 3 like they are written. The DON stated the CP was not followed and Resident 3 could get worse overall. The DON stated Resident 3's pain was not managed per the CP. The DON stated that Resident 3 had the right to be free from pain. The DON stated the policy and procedure (P&P) Pain- Clinical Protocol nor Care Plans, Comprehensive Person-Centered. During an interview on 10/28/24 at 10:05 a.m., with LVN 2, LVN 2 stated she was Resident 3's nurse today. LVN 2 state CP's identify what care needs to be done for the resident and they promote their safety. LVN 2 stated the CP for Resident 3 was not followed because of a miscommunication. LVN 2 stated staff failed to provide pain management for Resident 3 before his therapy. LVN 2 stated Resident 3 deserved to be free from pain and he was not per the CP. During a review of the facility's P&P titled, Pain- Clinical Protocol, dated October 2022, the P&P indicated, Assessment and Recognition: 1. The physician and staff will identify individuals who have pain or who are at risk for having pain. a. This includes reviewing known diagnosis and conditions that commonly cause pain . 2. The nursing staff will assess each individual for pain upon admission to the facility, at the quarterly review, whenever there is a significant change in condition, and where there is onset of new pain or worsening of existing pain . 3. The staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern, and severity . 4. The nursing staff will identify any situations or interventions where an increase in the residents pain may be anticipated . (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, Policy Statement: A comprehensive, person-centered care plan that includes measurable objectives (a goal that could be tracked and evaluated over time) and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being, including: . e. reflects currently recognized standards of practice for problem areas and conditions . 8. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: a. provided by qualified persons . 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, care consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . 10. interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 During observation, interview, and record review, the facility failed to ensure accurate labeling of resident medications, and storage of resident medications at proper temperatures to preserve their integrity in accordance with accepted professional standards of practice when: 1. One of two medication carts had two out of 199 pill packets with no visible expiration dates. 2. Seven out of seven boxed medications did not have the inside medication container labeled with resident information. 3. One of two medication refrigerators was below the facility required temperature range of 36 degrees Fahrenheit (F) and 46 degrees F. These failures put residents at risk for unsafe administration of medications. Findings: 1. During a concurrent observation and interview on 10/24/24 at 12:00 p.m. with Licensed Vocational Nurse (LVN) 2, in the B-wing nurse's station, the B-wing medication cart was observed to have two of 199 resident pill cards (a packet containing a set number of prefilled prescription medications) without visible expiration dates. LVN 2 stated the residents' medication pill cards should have had a visible expiration date. LVN 2 stated if nurses were unable to read the expiration date, the medication should not be given. LVN 2 stated the pharmacy should be called to advise if a new label would be sent, or if the nurse was to dispose of the medication and get a new medication card sent from the pharmacy. During an interview on 10/28/24 at 1:49 p.m. with the Director of Nursing (DON), the DON stated labeling residents' medications correctly was a facility policy. The DON stated her expectation was for the resident's correct name and the medication expiration date to be visible on the resident's medication. The DON stated if the medication was not labeled correctly, staff could harm the resident who received the medication. The DON stated the medication expiration date should have always been visible. The DON stated staff should have contacted the pharmacy if the medication expiration date was not visible. The DON stated it was important to see the medication expiration date because the medication could have expired. The DON stated expired medications could have lost their potency and not helped the resident who received the medication. During a review of the facility's job description (JD) document titled, Licensed Vocational Nurse, dated 3/2024, the JD indicated, . key responsibilities . dispense prescribed medications accurately . according to established protocols . maintain accurate medication records and documentation . During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, indicated, . medications are administered in a safe and timely manner . the expiration/beyond use date on the medication label is checked prior to administering . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Medication Labeling and Storage, dated 2/2023, indicated, . labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . the medication label includes, at a minimum . expiration date . if medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items . only the dispensing pharmacy may label or alter the label on a medication container or package . 2. During a concurrent observation and interview on 10/23/24 at 7:32 a.m. with LVN 2, outside of Resident 15's room, LVN 2 was observed removing an unlabeled bottle from a labeled box of eye drops. The box was observed to have Resident 15's name, the box opened date, and the use by date for the eye drops written on the inside of the box flap. LVN 2 stated over-the-counter medications did not have the resident's name written on the bottle, only the box was labeled. LVN 2 stated if the bottle came out of the labeled box in the medication cart, staff should throw the bottle away and get a new box. LVN 2 stated staff would not know who the bottle belonged to if the box was not labeled. During a concurrent observation and interview on 10/24/24 at 2:28 p.m. with LVN 3, in the nurse's station, the B-wing medication cart was observed to contain six boxes of eye drops and one inhaler with resident names on each box. The eye drop bottles inside each box were observed to have no labels on the medication bottles, and the inhaler inside the box had no label on the medication. LVN 3 stated the medication containers inside of the box should be labeled with the resident's name. LVN 3 stated if the medication came out of the unlabeled box, the medication could be given to the wrong person. LVN 3 stated an unlabeled eye drop bottle or inhaler could cause a medication error. During an interview on 10/28/24 at 1:49 p.m. with the DON, the DON stated labeling resident's medication bottles correctly was in the facility's medication policy. The DON stated it was important that the resident's medication was labeled with the correct resident's name and was readable. The DON stated if the medication was not labeled with the resident's name, staff could harm the resident. The DON stated the medication containers in boxes should be labeled. The DON stated the medication container could fall out of the box and staff would not know who it belonged to. During a review of the facility P&P titled, Medication Labeling and Storage, dated 2/2023, indicated, . labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . the medication label includes, at a minimum . resident's name . 3. During a concurrent observation and interview on 10/24/24 at 11:18 a.m. with the Minimum Data Set Nurse (MDSN) in the B-wing medication room, the medication refrigerator temperature was observed at 32 degrees Fahrenheit (F). The MDSN stated the refrigerator temperature of 32 degrees F was too cold to hold medications. The MDSN stated having the refrigerator temperature below the accepted temperature range of 36 degrees F could damage the medications and make them unsafe for resident use. During a concurrent interview and record review on 10/24/24 at 11:20 a.m. with the MDSN, the Temperature Log for Refrigerator (TL), dated [DATE] was reviewed. The TL indicated, . Danger! Temperatures below 36 degrees F are too cold! Write any out-of-range temps and room temp on the lines below . The MDSN stated if the refrigerator temperature was below the accepted temperature range, the medications in the refrigerator could be damaged. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/24 at 11:21 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the Infection Prevention (IP) Nurse kept track of the medication refrigerator temperatures. The ADON stated if the medication refrigerator temperature was out of range, the nurse should notify maintenance and call the pharmacist for guidance. During an interview on 10/24/24 at 2:20 p.m. with the MDSN, the MDSN stated the protocol for medication questions was to call the pharmacist for guidance. The MDSN stated the pharmacist informed her if the medications were not out of acceptable ranges for over 6 hours, the medications should be okay. The MDSN stated the pharmacist recommended staff to check the affected medications for crystallization (the process in which solids form in a liquid substance) prior to use on residents. During an interview on 10/28/24 at 1:49 p.m. with the Director of Nursing (DON), the DON stated her expectation was the medication refrigerator to be kept within the appropriate temperature range for holding resident medications. The DON stated if the medication refrigerator was not within the appropriate range, it could affect the resident's medication potency. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, indicated, . the facility stores all medications and biologicals . under proper temperature, humidity and light controls . During a review of the facility's policy and procedure titled, Pharmacy Services Overview, dated 4/2019, indicated, . medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice . the consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to) . receipt, labeling and storage of medications . facility staff roles and responsibilities during the receipt and storage of medication . During a review of the facility's policy and procedure titled, Pharmacy Services - Role of the Consultant Pharmacist, dated 4/2019, indicated . the consultant pharmacist will provide specific activities related to medication regimen review including . review of medication storage areas at least monthly, and medication carts at least quarterly, for proper storage and labeling of medications, cleanliness, and expired medications .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observations, interview, and record review the, the facility failed to ensure the physician order (set of instructions written by a doctor) was followed for one of the six sampled residents (Resident 14) was served an incorrect scoop size for small portion diet on 10/23/24. This failure had the potential for Resident 14 to received more than the recommended number of calories ordered by the physician. Findings: During an observation on 10/23/24 at 11:39 a.m. in the kitchen during tray line (food service assembly line system where workers add components to a tray as it moves along a line) Dietary [NAME] (DC) used number 8 scoop size on the steam table. DM stated he should have given less for residents with order for smaller portions. During an interview on 10/24/24 at 9:33 a.m. with the Dietary Services Supervisor, the DSS stated, there should be a number 8 scoop size regular portion) and number 10 scoop size (small portion) during tray line. The DSS stated, Resident 14 had an order for small size portion and serving size should be based on the smaller portion scoop. The DSS stated, it was important to follow portion size to prevent weight gain and loss. The DSS stated Resident 14 would have gained weight when the portion control size was not followed. The DSS stated, the DC should have looked at the meal ticket [a printed ticket that specifies each resident's meal) and should have served the items accordingly. The DSS stated, He [DC] did not do that. During an interview on 10/25/24 at 10:40 a.m. with the Registered Dietitian (RD), the RD stated, the DC should have all the number scoop size (8 and 10 portion) while serving food on the steam table. The RD stated, the DC should have used correct scoop size (10) for small portions for Resident 14. The RD stated, Resident 14 could have gained weight when given a larger scoop size. The RD stated, the physician order called for small portion and the order should have been followed. During a review of Resident 14 s Admission Record (document containing resident demographic information and medical diagnosis) dated 10/28/24, the admission record indicated Resident 14 was admitted to the facility on [DATE]. Resident 14's diagnosis included hypertension (high blood pressure), type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), anxiety disorder (a feeling of fear, dread, and uneasiness that can be a normal reaction to stress), gastritis (an inflammation of the stomach lining that can be short-term or long-term), gout (a type of arthritis that causes severe pain and swelling in joints due to a buildup of uric acid) and irritable bowel (chronic condition that affects the large intestine and causes a variety of symptoms). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 8/5/24 the MDS, indicated Resident 14 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 14 was cognitively intact. During a review of Resident 14's [Facility Name] Order Listing Report (OLR), dated 10/28/24, the OLR indicated, .Order Summary: CC/CRCS diet Mechanical Soft texture, thin consistency, Small Portion . During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 2011, the P&P indicated, .Portion control assures correct quantities are served to resident/patients to meet the nutritional specifications as determine by the menu .3. Scoops are sized according to the number of scoops needed to equal one quart. The smaller the number, the larger the size. Amount in Cups scoop size .1/2c [cup] 8 [scoop size] 3/8c [cup] 10 [scoop size] .7. Small portion may be given to resident/patients per physician order .food items should be reduced by 1/4 cup increments for entrees, starch, and vegetables .[box] regular portion: [box] 1 cup .[box] small portion: [box]:

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49949 Based on observation, interview and record review, the facility failed to ensure 56 of 56 sampled residents received safe and appetizing temperature food when Dietary [NAME] (DC) did not check temperature of food on steam table on 10/23/24 before serving. This failure had the potential for all 56 residents to be served cold food and for all 56 residents to contract food borne illnesses. Findings: During an observation on 10/23/24 at 10:19 a.m. in the kitchen with the DC, the DC removed tray #1 lasagna from oven and placed the lasagna on steam table. During an observation on 10/23/24 at 11:33 a.m. the DC removed tray #2 lasagna from oven and placed the lasagna on steam table. During an observation on 10/23/24 at 11:39 a.m. in the kitchen during tray line (food service assembly line system where workers add components to a tray as it moves along a line),the following items were observed on the steam table: tray #1 lasagna stacked on top of tray #2 lasagna, a silver tray of boiled vegetables, six foam containers (three pureed lasagna and three pureed vegetables) were on the steam table. DC did not check temperatures prior to putting food on the plate. During an interview on 10/23/24 at 12:15 p.m. with the DC, the DC stated, he did not check temperature of food on steam table. The DC stated, We don't have temperature logs for items on steam table. The DC stated he should have checked temperature of food prior to serving. The DC stated he was trained by the Dietary Services Supervisor (DSS) for four days. During an interview on 10/24/24 at 9:33 a.m. with the DSS, the DSS stated, the DC should have checked the temperature of the items on the steam table prior to serving. The DSS stated, checking the temperature of the items on the steam table ensures the food is warm and appropriate temperature prior to serving. The DSS stated, we want to make sure the food is warm for the Residents. The DSS stated, Residents do not like cold food and would not eat it. The DSS stated, residents lost weight when they refused to eat. The DSS stated, food should have been checked to make sure it was acceptable temperature and to prevent bacterial growth. The DSS stated, residents could get sick when consuming food below 165-degree Fahrenheit. During an interview on 10/24/25 at 11:43 a.m. with the Registered Dietitian, the RD stated, Prior to serving, food temperature should have been checked. The RD stated it was important to check food on steam table to ensure accurate temperature prior to serving. The RD stated checking temperature prior to serving was for food safety. The RD stated checking temperature will prevent bacterial growth that cause foodborne illness. The RD stated food was appetizing when served hot. The RD stated, food served cold resulted in residents eating less and had the potential to cause weight loss. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Proper Temperatures for meal preparation and service dated 2011, the P7P indicated, .[box] Food items [box] Casseroles .[box] hold temperature (minimum acceptable) [box] 140 [degree Fahrenheit] .[box] vegetables .[box]140 [degree Fahrenheit] .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 48424 Based on observation interview and record review the facility failed to ensure meal preferences were followed for one of seven residents (Resident 51) when Resident 51 was served items on her list of disliked foods of chicken with skin and beets. This failure had the potential to cause Resident 51 to experience inadequate nutrition and weight loss as a result of not eating. Findings: During a review of Resident 51's Admission Record (AR- a document which provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 10/24/2024, the AR indicated Resident 51 was admitted with the following conditions: diverticulitis(swelling or infection of small pouches in the intestines), protein calorie malnutrition (occurs when a person does not eat enough protein and calories in their food to meet their nutritional needs), and diarrhea (frequent loose-bowel movement) During a review of Resident 51's Minimum Data Set (MDS- resident assessment tool which indicates physical and cognitive abilities), dated 8/5/2024, the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), indicating Resident 51 had no cognitive impairment. During a concurrent observation and interview on 10/22/24 at 12:07 p.m. in Resident 51's room, Resident 51 was served chicken with skin, beets, and bread. Resident 51 stated she did not like skin on her chicken, or beets. Resident 51 stated she had diverticulitis, and she did not want to eat meat with skin or vegetables because it could cause her upset stomach. Resident 51 stated she did not want to eat her provided lunch. Resident 51 stated she often received meat with skin on it or a lot of fiber (parts of foods the body can't digest or absorb) from the kitchen. During an interview on 10/24/24 at 11:33 a.m. with the Registered Dietitian (RD), the RD stated Resident 51's preference for meat without skin should have been followed. The RD stated if Resident 51's meal preferences were not followed, it could have led to Resident 51 not eating and experiencing malnutrition (lack of nutrients received from food). During an interview on 10/25/24 at 10:46 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated nurses were the ones responsible for checking meal trays to ensure they followed resident meal preferences, but CNAs were also able to view the trays to ensure residents received the correct and preferred food items. CNA 7 stated if she or other CNAs noticed a resident repeatedly refusing their tray they would need to inform the nurse in order to correct the problem. CNA 7 stated it was important to follow a resident's meal preferences and orders because not doing so could lead residents to experience weight loss from not eating. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	2280 Dockery Avenue Selma, CA 93662

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/25/24 at 11:19 a.m. with the Director of Staff Development (DSD), the DSD stated nurses were the ones responsible for checking meal tray's meal ticket (a document which lists resident preferences and diet order) to ensure the meals were accurate to what the resident should be receiving. The DSD stated CNAs could have also checked the tray for accuracy as they delivered it to the residents. The DSD stated if a resident's preference wasn't followed, or a food error was found, the expectation was for CNAs to alert the nurses of the error or to go to the kitchen to let kitchen staff update the resident's meal ticket. During a concurrent interview and record review on 10/28/24 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 51's Order Summary Report, dated 10/24/24 was reviewed. The Order Summary report indicated Resident 51 was on a low fiber diet. LVN 2 stated Resident 51 had diverticulitis and eating food with fiber like beets or chicken with skin was not good for her. LVN 2 stated Resident 51's meals should follow her preferences and dietary restrictions because eating foods she's not supposed to eat could cause pain and swelling in her stomach. During an interview on 10/28/24 at 11:27 a.m. with the Director of Nursing (DON), the DON stated Resident 51 should not have gotten an incorrect lunch meal, she had a diagnosis of diverticulitis and has had a lot of issues with it. The DON stated the diet order needed to be followed and Resident 51 should have gotten an appropriate meal the first time without having to ask for an alternative. During a review of Resident 51's meal tickets, dated 1021/24-10/23/24, indicated Resident 51's dislikes were: nuts, beans, pork, beef, and chicken with skin. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, dated 10/2017, indicated, . Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes . A 'therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview and record review, the facility failed to store, prepare, and serve food in accordance with professional standards of practice for food service safety when: 1. A walk- in freezer had beef stew meat with ice crystals inside the bag labeled [DATE]. 2. A foam cup containing food with staff name undated labeled was stored on shelf in walk-in refrigerator. 3. An open yogurt container with no opened date was found in the walk-in refrigerator 4. A white bin containing oats was not labeled with open and received date in the storage room. 5. Cookies, snacks and 2-liter sodas brought from family members, were found with no label of date opened, date received, or initials, in two of six sampled residents' (Resident 2 and 24) room. These failures had the potential to transmit food-borne illnesses to residents. 1. During a concurrent observation and interview on [DATE] at 8:23 a.m. in the walk- in freezer with the Dietary Service Supervisor (DSS) a bag containing stew meat dated [DATE] had ice crystals inside. The DSS stated, she was going to throw the stew meat away. During an interview on [DATE] at 9:33 a.m. with the DSS, the DSS stated, frozen meat was good up to 6 months and the stew meat was not right. The DSS stated, the stew meat had freezer burn (condition that occurs when frozen food loss moisture and dried out due to exposure to air) and it should have been thrown away. The DSS stated, the stew meat was used on an old menu and the old menu was discontinued. The DSS stated, We go through our meat every seven days. The DSS stated, the stew meat should have been thrown away when menu was discontinued. The DSS stated, expired stew meat lowered taste and quality and residents would not eat it. During an interview on [DATE] at 11:38 a.m. with the Registered Dietitian (RD), the RD stated the stew meat with freezer burn should have been thrown away. The RD stated, stew meat had compromised quality and taste. The RD stated, Residents would not eat it. The RD stated the stew meat had potential to contain bacteria. The RD stated freezer burned stew meat could have caused food poisoning and had potential to get residents sick. The RD stated staff should have noticed stew meat and should have thrown it out. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control dated 2011, the P&P indicated, Subject: Freezer Storage .4. New items should be placed behind older items .5. All foods should be stored in an airtight moisture-resistance wrapper such as a plastic bag or freezer paper to prevent freezer burn . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the professional reference titled, What is Freezer burn? dated [DATE], retrieved from, https://ask.usda.gov/s/article/What-is-freezer-burn, the article indicated, Freezer burn appears as grayish-brown leathery spots on food and is caused by air reaching the surface of the food .Heavily freezer-burned foods may have to be discarded for quality reasons . 2. During a concurrent observation and interview on [DATE] at 8:40 a.m. in the walk-in refrigerator with the DSS, a foam cup containing food had staff name without no labeled dated next to resident food on a shelf. The DSS stated the foam cup should not be mixed with resident food and it should be labeled with date. During an interview on [DATE] on 9:33 a.m. with the DSS, the DSS stated the foam cup should have been stored in staff bin (a container where staff stored all personal items). The DSS stated the foam cup had potential to be mixed with resident's food and served to residents. The DSS stated staff should have thrown it away. During an interview on [DATE] on 11:43 a.m. with the RD, the RD stated staff should have a designated area for their items. The RD stated, the foam cup should have been stored inside staff bin. The RD stated all staff items should be stored inside staff bin. The RD stated items stored in staff bin prevented cross contamination. The RD stated, staff items stored outside staff bin caused confusion for staff. The RD stated residents could have been served food meant for staff. The RD stated, Residents could have potentially gotten food that belong to the staff members and we do not know if resident might eat it. The RD stated, cross contamination could have resulted when residents were served food eaten by staff. The RD stated, residents could have an allergic reaction from the ingredients inside the foam cup. The RD stated, staff should have dated the foam cup to prevent serving food past expiration. The RD stated, following storing practices could have prevented confusion. During a review of the facility's policy and procedure (P&P) titled, Dietary Staff Food Storage dated , d+[DATE], the P&P indicated, .Dietary Saff may keep their refrigerated items in a separate bin within the walk-in-refrigerator. This must be labeled and dated. The items will not be stored on the shelf outside of the bin with the resident's food items. It is the responsibility of the Dietary staff to keep their items dated and clean bin weekly by a designated staff member . 3. During a concurrent observation and interview on [DATE] at 8:40 a.m. in the walk -in refrigerator with the DSS, an open yogurt container was labeled with received dated [DATE] and no open date. The DSS stated, open yogurt container should have an open date labeled. During an interview on [DATE] at 9:45 a.m. with the DSS, the DSS stated, open yogurt container needed to have an open date when it was opened. The DSS stated, open yogurt containers without date should have been thrown out. The DSS stated, undated opened yogurt could have been served to Residents. The DSS stated, resident can get sick from eating expired yogurt. During an interview on [DATE] at 11:43 a.m. with the RD the RD stated, yogurt containers should date when opened. The RD stated the open date was important to know when to throw it away. The RD stated, undated yogurt containers could have been served past expiration dates. The RD stated, undated open yogurt could have mold and bacteria and it could have been served to residents and could have gotten them sick. The RD stated, staff should have thrown it out. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control dated 2011, the P&P indicated, .9. Leftover food or unused portion of packaged foods should be covered, labeled, and dated to assure they will be used first . 4. During a concurrent observation and interview on [DATE] at 9:50 a.m. in the storage pantry in the kitchen, a plastic storage bin containing oats was not labeled with an opened and received date. The DSS stated, storage bins should have been labeled with both and opened and received dates. During an interview on [DATE] at 9:33 a.m. with the DSS, the DSS stated, staff should have labeled the oat bin with opened and received dates. The DSS stated, it was important to have both dates on the bin to prevent mixing old items with new items. The DSS stated, the staff did not follow the policy when the oat bin was not labeled with an opened and received date. During an interview on [DATE] at 11:43 a.m. with the RD, the RD stated, the bin for oats should have been labeled with a received and opened date. The RD stated, When in doubt throw it out The RD stated, it was important to label the bin with an opened and received date to prevent residents from consuming expired oats. The RD stated residents could have gotten sick if they ate the expired oats. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control dated 2011, the P&P indicated, Subject: canned and Dry Goods Storage .15. Bins holding dry goods such as flour, sugar, etc, must be clearly labeled on the lid and front of the container and dated when produces were put into bin . 5. During a review of Resident 2 s Admission Record (document containing resident demographic information and medical diagnosis) dated [DATE], the admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 's diagnosis included hypertension (high blood pressure), Alzheimer's disease (a brain disorder that gradually destroys memory and thinking skills, and eventually the ability to perform basic tasks), chronic kidney disease (a condition where the kidneys are damaged and can't filter blood properly), type 2 diabetes (a condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) and depression. During an observation on [DATE] at 10:30 a.m. in Resident 2's room, two bottles of tamarind soda with no received date and no initials were on the nightstand. During an interview on [DATE] at 3:45 p.m. in Resident 2's room, Certified Nurse Assistant (CNA) 4 verified there were two unlabeled bottles of tamarind soda in Resident 2's room. CNA 4 verified one bottle was opened. CNA 4 stated, opened two-liter soda should be labeled with an open date and Resident 2's initials. CNA 4 stated, the opened two-liter soda should have been refrigerated. CNA 4 stated, it was important to label the two-liter soda to prevent Resident 2 from consuming it past expiration date. CNA 4 stated Resident 2 could have gotten sick when he consumed expired soda. During a concurrent observation and interview on [DATE] at 10:42 a.m. in Resident 2's room with Licensed Vocational Nurse (LVN) 2, LVN 2 verified two tamarind soda bottles were on the table with no date and no initial. LVN 2 stated, two-liter sodas needed to be labeled with date, time, and resident initials. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 27s Admission Record (document containing resident demographic information and medical diagnosis) dated [DATE], the admission record indicated Resident 27 was admitted to the facility on [DATE]. Resident 27 's diagnosis included Parkinsons disease (chronic, progressive brain disorder that causes movement problems and other symptoms), protein-caloric malnutrition (the state of inadequate intake of food (as a source of protein, calories, and other essential nutrients) and pain. During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE] the MDS, indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 15 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact) indicating Resident 27 was cognitively intact. During an observation on [DATE] at 11:35 a.m. in Resident 27's room one plastic container contained cookies, one plastic container contained crackers and one plastic container was empty. During an interview on [DATE] at 3:30 p.m. with Resident 27, Resident 27 stated, his family member brought cookies to the facility last week. During an interview on [DATE] at 3:23 p.m. with LVN 4, LVN 4 stated, Resident 27's family brought cookies and snacks from home. LVN 4 stated, there should be a date on the cookie container. LVN 4 stated she was not sure how long the cookies were kept in the container. During an interview on [DATE] at 3:35 p.m. in the hallway with CNA 5, CNA 5 stated she worked for the facility for [AGE] years. CNA 5 stated plastic containers with cookies and crackers should have a label with received and open date. CNA 5 stated cookies received from family member were good for three days. CNA 5 stated snacks were kept in resident utility room or refrigerator. CNA 5 stated, it was important to labeled items with received and open date to ensure food was not expired. During an interview on [DATE] at 3:53 p.m. with CNA 6, CNA 6 stated, she had worked for the facility for seven years. CNA 6 stated Resident 27 had cookies in clear plastic containers with no date or initials. CNA 6 stated cookies should have been labeled with received date and Resident 27's name. CNA 6 stated it was important to label received date on cookies and snacks so Resident 27 would not be given expired items. CNA 6 stated, expired cookies or crackers could have caused Resident 27 to be sick. CNA 6 stated cookies brought in by Resident 27's family member should be thrown away after three days. CNA 6 stated, CNAs were responsible to clean resident tables and to label cookies. CNA 6 stated she did not remember the last time she cleaned Resident 27's table. During an interview on [DATE] at 10:27 a.m. with LVN 2, LVN 2 stated, Resident 27's family member brought cookies and snacks. LVN 2 stated, staff should have labeled cookies and snacks when it was opened. LVN 2 stated all staff were responsible to check the cookies and snacks for residents. LVN 2 stated cookies and snacks brought in by family member were kept in the refrigerator for seventy-two hours. LVN 2 stated, we should have labeled the cookies with open date to prevent Resident 27 from consuming expired cookies. LVN 2 stated, cookies with open date prevented food borne illness. LVN 2 stated, expired food caused health issues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 1:40 p.m. with the Director of Staff Development (DSD), the DSD stated staff were trained in labeling food and sodas brought in by family members. The DSD stated new hires were trained to label food and sodas brought in by family members during orientation. The DSD stated dating food was important to prevent residents from consuming expired food. The DSD stated all staff members were educated about the safety of expired food. During an interview on [DATE] at 2:19 p.m. with the Director of Nursing (DON), the DON stated food brought in by family members should have an open date label. The DON stated food that was left over for more than three days should have been tossed or thrown away. The DON stated food items should have been labeled with received date and resident name. The DON stated, food brought in by family members was sensitive and could have effect on the residents. The DON stated anytime family members bring food, the CNA should notify the charge nurse. The DON stated the policy is to date the food when it arrives. The DON stated it was important to date it for resident safety. During a review of the facility's policy and procedure (P&P) titled, Food brought by Family/Visitors revised date ,d+[DATE], the P&P indicated, .Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable from facility-prepared food .containers are labeled with the resident's name, the items and the 'used' by date .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on interview and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards of practice for one of six sampled residents (Resident 8), when Resident 8's antipsychotic consent forms were incomplete. This failure put Resident 8 at risk of receiving antipsychotic medication prior to being informed of the risks and benefits of taking the medication. Findings: During a review of Resident 8'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 10/28/24, the AR indicated Resident 8 was admitted on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), delusional disorder (a type of mental health condition in which a person can't tell what is real from what is imagined), and schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly). During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 9/30/24, the MDS section C indicated Resident 8 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 8 was severely impaired. During a concurrent interview and record review on 10/25/24 at 3:16 p.m. with the Director of Nursing (DON) Resident 8's Antipsychotic Consent Forms, dated 3/5/24 and 9/4/24 were reviewed. The Antipsychotic Consent Forms indicated the physician signatures were not dated for Quetiapine (an antipsychotic medication that treats schizophrenia). The DON stated the signed consent forms for Quetiapine should have been dated by the physician. The DON stated the consents for Resident 8's antipsychotic medications were not valid without a dated physician's s signature. The DON stated Medical Records Department was responsible for verifying consents were completed. The DON stated nurses were to verify consents were complete before administering antipsychotic medications to the residents. The DON stated without a dated signature, staff could not verify consent was obtained prior to the resident starting the medication. The DON stated Resident 8's consent needed to be signed and dated prior to Resident 8 receiving the antipsychotic medication. The DON stated her expectation was consents be complete with signatures dated by the physician. (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 concurrent interview and record review on 10/28/24 at 3:42 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 8's Antipsychotic Consent Form, dated 3/5/24 and 9/4/24 were reviewed. The Antipsychotic Consent Form indicated the physician signatures on the 3/5/24 and 9/4/24 consents were not dated. LVN 4 stated the LVNs check resident's antipsychotic consents prior to giving the medication to verify the consents were complete. LVN 4 stated Resident 8's March and September consents for Quetiapine were not complete without the date of the physician's signature. LVN 4 stated the date of the physician's signature was important to know when the doctor obtained Resident 8's consent for the medication, and to be sure Resident 8 consented to receiving the medication prior to staff giving the medication to Resident 8. During a review of the facility job description (JD) document titled, Medical Records Technician, dated 1/2024, the JD indicated, . key responsibilities . audit records regularly to verify accuracy and completeness . identify record discrepancies and communicate with relevant staff to resolve them . During a review of the facility's policy and procedure (P&P) titled, Informed Consent, dated 7/2019, indicated, . Licensed Nurse verification that a physician has obtained IC (Informed Consent) medical services, treatments, medications . requiring IC . any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include, but are not limited to the following categories: anti-psychotics . IC will be verified by the facility with each order . In the event the physician has NOT obtained informed consent and/or the facility cannot verify such informed consent, then the facility may not administer psychotropic medications .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49949 Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe and sanitary environment and to help prevent the development and transmission of infections for 56 of 56 sampled residents when Contractor Technician (CT) did not wash his hands upon entering kitchen. This failure had the potential to cause cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and foodborne illnesses to 56 residents, staffs and visitors that received ice from the ice-machine. Finding: During a concurrent observation and interview on 10/25/24 at 8:55 a.m. in the kitchen, a contractor technician (CT) walked to ice-machine and started scooping ice from bin without washing his hands. The CT stated, he did not wash his hands prior to scooping ice. The CT stated he should have washed his hands when entering kitchen. The CT stated hand washing was important to prevent the spread of cross-contamination (the physical movement or transfer of harmful bacteria from one person, object, or place to another). The CT stated, cross-contaminated ice could have caused residents to be sick. During an interview on 10/25/24 at 9:33 a.m. with the DSS, the DSS stated, the CT should have washed his hand. The DSS stated, anyone entering kitchen should wash their hands. The DSS stated, hand washing was important to prevent germs and bacteria from outside. The DSS, stated unwashed hands can cause contamination and residents could have gotten sick. During an interview on 10/25/24 at 11:43 a.m. with the RD, the RD stated, the CT should have washed his hands when entering the kitchen. The RD stated, the CT could have touched things in the kitchen and caused cross-contamination and spread bacteria to residents served ice. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control dated 2011, the P&P indicated, . Handwashing. Frequency.1. Before starting work in the kitchen . During a review of the professional reference titled, Food Contamination and Foodborne Illness Prevention? dated 4/3/23, retrieved from https://www.health.state.mn.us/people/foodsafety/prevention.html, the article indicated, .Food becomes contaminated through a variety of mechanisms. Some things that can contribute to foodborne illness are: inadequate handwashing, cross-contamination, storage and cooking temperatures .

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 10/28/2024
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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview and record review, the facility failed to monitor and maintain essential equipment in a safe operating condition for one of two medication room refrigerators, when the refrigerator temperature reading was below the acceptable range for safe holding of medication. This failure had the potential to put residents whose medications were held in the B-wing medication refrigerator at risk of receiving unsafe and ineffective medications. Findings: During a concurrent observation and interview on 10/24/24 at 11:18 a.m. with the Minimum Data Set Nurse (MDSN) in the B-wing medication room, the medication refrigerator temperature was observed at 32 degrees Fahrenheit (F). The MDSN stated the refrigerator temperature of 32 degrees F was too cold to hold medications. The MDSN stated having the refrigerator temperature below the accepted temperature range of 36 degrees F could damage the medications and make them unsafe for resident use. During a concurrent interview and record review on 10/24/24 at 11:20 a.m. with the MDSN, the Temperature Log for Refrigerator (TL), dated [DATE] was reviewed. The TL indicated, . Danger! Temperatures below 36 degrees F are too cold! Write any out-of-range temps and room temp on the lines below . The MDSN stated if the refrigerator temperature was below the accepted temperature range, the medications in the refrigerator could be damaged. During an interview on 10/24/24 at 11:21 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the Infection Prevention (IP) Nurse kept track of the medication refrigerator temperatures. The ADON stated if the medication refrigerator temperature was out of range, the nurse should notify maintenance and call the pharmacist for guidance. During a concurrent observation and interview on 10/24/24 at 11:22 a.m. with the Maintenance Director (MAINTD) in the B-wing medication room, the temperature of the medication refrigerator was observed to be at 41 degrees F. The MAINTD stated the refrigerator temperature would have risen quickly if the medication refrigerator door was open. The MAINTD stated the temperature control knob was set too low. The MAINTD adjusted the temperature control knob to 41 degrees F. During an interview on 10/24/24 at 2:18 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the B-wing medication refrigerator leaked water on the counter. LVN 2 stated since the medication refrigerator was out of range, it needed to be defrosted to reset. LVN 2 stated the medications in the B-wing medication refrigerator were moved to the C-wing medication refrigerator. During an interview on 10/24/24 at 2:20 p.m. with the MDSN, the MDSN stated the protocol for medication questions was to call the pharmacist for guidance. The MDSN stated the pharmacist informed her if the medications were not out of acceptable ranges for over 6 hours, the medications should have been okay. The MDSN stated the pharmacist recommendations were for staff to check the affected medications for crystallization (the process in which solids form in a liquid substance) prior to use on residents. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/24/24 at 3:10 p.m. with LVN 3, LVN 3 stated staff would notify maintenance of needed repairs by filling out a form kept in a binder at the nurse's station. LVN 3 stated nurses could also go on-line to request maintenance. During an interview on 10/25/24 at 9:25 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated staff would contact maintenance using walkie-talkies (a hand-held, portable, two-way radio transceiver), phone call, or by filling out a paper form and putting it in a box by the nurse's station. CNA 3 stated the facility now had an on-line system the nurses would complete for maintenance requests. During an interview on 10/25/24 at 2:44 p.m. with the MAINTD, the MAINTD stated staff would use a computer requisition system (TEAMS) to notify him of repairs that were needed. The MAINTD stated staff could also request repairs by completing a paper form. The MAINTD stated the medication refrigerators were not checked regularly for maintenance. The MAINTD stated there was no maintenance log for the medication refrigerators. The MAINTD stated the only maintenance log for the medication refrigerators was when the nurses would check the refrigerator temperature and write it down in the log. The MAINTD stated the medication refrigerator in B-wing was not repairable and would need to be replaced. During an interview on 10/28/24 at 1:49 p.m. with the Director of Nursing (DON), the DON stated her expectation was the medication refrigerator to be kept within the appropriate temperature range for holding resident medications. The DON stated if the medication refrigerator was not within the appropriate range, it could affect the resident's medication potency. During a review of the facility job description (JD) titled, Maintenance Technician, dated 6/2024, the JD indicated, . the maintenance technician is responsible for the upkeep and repair of the facilities, equipment, and grounds . this role ensures a safe, comfortable, and well-maintained environment for residents, staff, and visitors . conduct regular inspections and maintenance of the building, equipment, and grounds . implement and document a preventative maintenance schedule to ensure all systems and equipment are functioning efficiently and safely . keep detailed records of all maintenance activities, including repairs, inspections, and preventative maintenance tasks . During a review of the facility job description (JD) titled, Maintenance Supervisor, dated 8/2024, the JD indicated, . this role involves . managing preventative maintenance schedules . handling repairs . develop and implement preventative maintenance programs for all building systems . maintain records of inspections, maintenance activities, and compliance documentation . During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, indicated, . the facility stores all medications and biologicals . under proper temperature, humidity and light controls .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review, during the survey period of 10/22/24 to 10/28/24, the facility failed to provide the minimum of at least 80 square feet per resident in multiple resident rooms (Rooms 27, 28, 29, 31, 32, 33, 34, 35, 36, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59 and 60). This failure had the potential for residents to not have reasonable accommodations for privacy or adequate space for care to be rendered. Findings: During a concurrent observation and interview on 10/28/24 at 8:58 a.m. with the Maintenance Supervisor (MS), an environmental tour was conducted. The MS measured 22 resident rooms as follows: Room Number Square Feet Number of Residents 27 154 2 28 154 2 29 154 2 31 154 2 32 154 2 33 154 2 34 154 2 35 154 2 36 154 2 47 154 2 48 154 2 50 154 2 51 154 2 52 154 2 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bethel Lutheran Home	2280 Dockery Avenue Selma, CA 93662

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	53 154 2 54 154 2 55 154 2 56 154 2 57 154 2 58 154 2 59 154 2 60 154 2 During an interview on 10/25/24 at 10:30 a.m. With Certified Nursing Assistant (CNA) 7, CNA 7 stated she had worked at the facility for seven years and the resident room sizes had not been an issue. CNA 7 stated there was enough room for resident care and storage. CNA 7 stated she had not received any resident complaints regarding their room size. During an interview on 10/25/24 at 3:00 p.m. with Resident 51, in room [ROOM NUMBER], Resident 51 was lying in bed. Resident 51 stated she had no issues with the size of her room. Resident 51 stated she had enough privacy and room for storage. During the observations made from 10/22/24 to 10/28/24, variations were in accordance with the needs of the residents. The residents had a reasonable amount of privacy. Closets and storage space were adequate. Bedside stands were available. There was sufficient room for nursing care and for residents to ambulate. Wheelchairs and toilet facilities were accessible. The waiver will not adversely affect the health and safety of residents. Recommend waiver continue in effect. Health Facility Evaluator Supervisor Signature & Date Request waiver continue in effect. ______________________________ Administrator Signature & Date