| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555924 | A. Building<br>B. Wing | 12/05/2025 |

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| Bethel Lutheran Home | 2280 Dockery Avenue<br>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.

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain an effective infection prevention and control program for 49 of 49 sampled residents when: 1. Licensed Vocational Nurse (LVN) 4 went into Resident 1's room, who was on contact precautions (requiring staff and visitors to wear gloves and gowns when entering the room, wash hands thoroughly, and use special equipment to prevent touching the patient or their stuff to stop germs from spreading from a sick person to others), and performed patient care without wearing personal protective equipment (PPE) such as a gown and gloves. This failure placed all residents LVN 4 came in contact with at risk for cross contamination (when harmful bacteria move from one item to another), of bacteria that could result in resident infections and illness. 2. The dietary cook (DC) 1 was observed cooking with his side beard exposed and did not have a hair net covering that area. This failure had the potential to put residents at risk of cross contamination that could result in the transmission of infections and pathogens (germs that invade the body and cause illness) which could lead to infection, hospitalization, or death. 1. During a review of Resident 1's admission Record (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), dated 12/5/25, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with a diagnosis of hemiplegia (the paralysis or severe weakness affecting one entire side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke where a blood clot blocks a blood vessel in the brain, cutting off oxygen and nutrients, causing brain cells to die) affecting right dominant side and methicillin staphylococcus aureus infection (MRSA- a dangerous, contagious bacterial infection resistant to many common antibiotics, often starting as skin issues like red, swollen, pus-filled sores resembling boils or spider bites, but can spread to cause severe infections in blood, lungs, or bones. Spread through skin-to-skin contact or contaminated surfaces, it's treated with specific antibiotics and by draining abscesses, with prevention focusing on hygiene like frequent handwashing and covering wounds). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated 10/16/25, the MDS assessment indicated Resident 1's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 7 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 1 was severely impaired. During a review of Resident 1's Order Summary Report (OSR), dated 12/5/25, the OSR indicated .Order Summary: . Contact Precautions due to wound with MRSA as per Centers for Disease Control and Prevention/. facility policy. Active: 10/10/25. During an observation on 12/3/25 at 2:20 p.m., in Resident 1's room, Resident 1's door when entering her room has a sign labeled .CONTACT PRECAUTIONS. STOP. Perform hand hygiene before entering and before leaving room. Wear gloves when entering room and when touching patients intact skin, surfaces, or articles in close proximity. Wear gown when entering room and whenever anticipating that clothing will touch patient items or potentially contaminated environmental surfaces. Resident 1 also had a cart with gown and gloves<br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | outside of her room that was not accessed. LVN 4 walked into her room without personal protective equipment (PPE -staff use things like gloves, masks, and gowns to create a barrier that prevents the spread of invisible germs (viruses, bacteria) going between sick people and the healthcare workers) and turned the resident's body while adjusting her pillows underneath her right side. LVN 4 made contact with the resident, her bed and her pillows. During an interview on 12/3/25 at 4:15 p.m., with LVN 4, LVN 4 stated Resident 1 was on contact precautions for a MRSA infection. LVN 4 stated the expectation for a resident on contact precautions is to wear the proper PPE, which would be a gown and gloves before she interacted with the resident. LVN 4 stated she did not put any PPE on before having given Resident 1 care and she should have. LVN 4 stated she could have cross contaminated other residents that she interacted with after she left Resident 1's room. LVN 4 stated by not having worn PPE, other Residents could potentially get sick from her error. During an interview on 12/5/25 at 2:33 p.m., with Charge LVN 1, LVN 1 stated Resident 1 was on contact precautions and PPE needed to be put on before any staff member enters her room. LVN 1 stated if PPE was not worn when providing care for Resident 1, her MRSA infection could spread to other residents. During an interview on 12/5/25 at 2:33 p.m., with the Infection Preventionist (IP), the IP stated the expectation for all staff was to gown and glove up when caring for Resident 1. The IP stated Resident 1 had MRSA diagnosis and this was a highly contagious infection. The IP stated PPE should be put on before entering Resident 1's room and it was not. The IP stated staff should take off the PPE before leaving the room and there was a sign on Resident 1's door that said what should be done. The IP stated LVN 4 did not meet the facility expectation and could have cross-contaminated the infection to herself, co-workers, family members, or other residents. The IP stated that facility's policy and procedure Isolation- Categories of Transmission Based Precautions was not followed. During an interview on 12/5/25 at 3:12 p.m., with the Director of Nursing (DON), the DON stated the PPE expectation when entering Resident 1's room was not met. The DON stated there was a contact precautions sign on Resident 1's door that explicitly said what to do in order to care for her. The DON stated all of the supplies (gown, gloves) were right outside her room in the hallway. The DON stated cross contamination to other residents could occur and they could become ill. The DON stated the facility policy and procedure Isolation- Categories of Transmission Based Precautions was not followed. During review of the facility's policy and procedure (P&P) Isolation- Categories of Transmission Based Precautions, dated September 2022, indicated, .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. Contact Precautions. Contact precautions are implemented for residents with known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care [BB1] [LP2] items in the residents environment. Staff and visitors wear gloves (clean, non-sterile) when entering the room. hand hygiene performed before leaving the room. staff avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed. During a review of National Library of Medicine.org professional reference titled, Precautions, Bloodborne, Contact, and Droplet, dated 9/4/23 (found at https://www.ncbi.nlm.nih.gov/books/NBK551555/) the reference indicated, . Contact Precautions. Defined as direct or indirect contact with a patient and/or his or her environment including person's room or objects in contact with the person, that has an infection with. such as methicillin-resistant Staphylococcus aureus (MRSA). PPE defined by the CDC required before entering a contact precaution designated room is always gloves and a gown. Health-care team members, including physicians, nurses, and nursing assistants, should pay close attention to proper PPE use and isolation precautions for the personal safety and safety of the patients. It is also crucial for team members to enforce isolation precautions on visitors and other<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | members not complying with standard protocols to reduce infection transmission within the workplace. 2. During an observation on 12/3/25 at 11:18 a.m. in the kitchen, DC 1 wore a hair restraint (a hairnet that keeps a person's beard completely covered) while he cooked. DC1's hair restraint did not cover his entire beard and left his side beard exposed with no hair restraint covering the area.During a concurrent observation and interview on 12/3/25 at 11:19 a.m. with the Dietary Supervisor (DS) in the kitchen, DC1 was observed cooking with side beard exposed and no hair restraint covering the area. The DS stated all hair including facial hair must always be covered with a hair restraint. The DS stated she spoke to DC1, DC1 adjusted his hair restraint to cover his side beard and washed his hands. The DS stated that it was important to have all hair covered so that hair did not get on the food and contaminate it. The DS stated that if a resident found hair on their food it could lead to the resident refusing to eat it.During an interview on 12/5/25 at 7:52 a.m. with the Director of Staff Development (DSD)/ Infection Preventionist (IP), DSD/IP stated she audits the kitchen once a week for infection control practices (set of practices and procedure used to stop germs from spreading and causing illness) and checks the staff for hair restraints, hand hygiene, and cleanliness. The DSD/IP stated that her expectation in the kitchen was that all hair be covered at all times to avoid hair falling on the food and contaminating it. The DSD/IP stated hair has bacteria on it and could lead to foodborne illness (a sickness caused by eating or drinking contaminated food, water, or beverages) and cross contamination. The DSD/IP stated if a resident were to find hair on their food, it could lead to the resident's loss of appetite and refusal of food. DSD/IP stated the facility had a vulnerable population and refusing to eat the food could lead to weight loss and cause serious health problems for the resident. DSD/IP stated the facility's policy was to have hair covered at all times while in the kitchen.During an interview on 12/5/25 at 2:13 p.m. with the Director of Nursing (DON), the DON stated her expectation in the kitchen was that all hair needed to be covered the entire time staff was in the kitchen to minimize the chance of hair falling into the food. The DON stated if hair were to fall into the food, it would cause cross contamination that could lead to foodborne illness. The DON stated the facility's policy was not followed for infection control in the kitchen when DC 1's beard was not covered completely.During a review of the facility's Diet Type Report, dated 12/4/25, the Diet Type Report indicated, 49 out of 49 residents at the facility received food from the kitchen.During a review of the facility's policy and procedure (P&P) titled, Food Preparation and Service, (undated) the P&P indicated, .General Guidelines.2.Cross-Contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms [bacteria, viruses, etc. not seen with the naked eye] are transferred. 3.Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness.Food Distribution and Service.8.Food and nutrition services staff wear hair restraints (hair net, hat, beard restraint, etc.) so that hair does not contact food.During a review of the Food and Drug Administration (FDA) Food Code 2022, Hair restraints section 2-402.11, indicated, .FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>Based on interview and record review, the facility failed to ensure pharmaceutical services kept accurate records for 23 out of 23 residents when 37 controlled substance medication (medication with a high potential for physical and mental dependence) entries, from 6/26/25-11/18/25, did not have a Registered Nurse witness signature for destruction on 11/20/25 in the controlled drug disposition log. This failure resulted in inadequate record keeping of controlled substance medication which had the potential to lead to inaccurate controlled medication inventory, diversion (when healthcare providers obtain or use prescription medicines illegally) of controlled medications and delayed identification of controlled medication diversion. During a concurrent interview and record review on 12/4/25 at 3:25 p.m. with the Director of Nursing (DON) the facility's Controlled Drug Disposition Log (CDL), dated 6/26/25-11/18/25, was reviewed. The DON stated the CDL required all entries to be filled out on the form to be considered complete and accurate. The DON stated the DON and the Consultant Pharmacist (CP) destroyed controlled medications together and both signed the CDL to ensure controlled substance medications were accounted for and disposed of. The DON stated on 11/20/25 she destroyed 37 controlled substance medications, which had been held from 6/26/25-11/18/25, for 23 residents with the CP. The DON stated she did not sign the 37 controlled substance medication entries for destruction on 11/20/25. The DON stated her destruction signature as the witnessing Registered Nurse was required to ensure the CP destroyed the correct medication in the correct quantity. The DON stated it was important the CDL was correctly and accurately completed to prevent drug diversion and ensure all controlled substance medications were accounted for and destroyed accurately with the CP. During an interview with the Consultant Pharmacist (CP) on 12/5/25 at 11:44 a.m., the CP stated he visited the facility monthly and destroyed controlled substance medication as needed. The CP stated controlled substance medication destruction timeframes varied depending on the controlled substance medication lock box capacity. The CP stated he destroyed controlled substance medication with the DON when the controlled substance medication lock box reached capacity. The CP stated before medication destruction a verification of medication and quantity was confirmed, and both the CP and the DON signed the CDL. The CP stated all entries on the CDL were required to be filled out and completed to ensure accurate tracking and destruction of controlled substance medication. The CP stated the DON's signature was required on the CDL to ensure a verification of controlled substance medication destruction occurred. During an interview on 12/5/25 at 2:13 p.m. with the DON, the DON stated her signature was required on the CDL for each resident's controlled substance medication disposal date. The DON stated her signature ensured the CP had a witness when destroying controlled substance medications and all medications were accounted for at the time of destruction. The DON stated facility policy and procedure was not followed on 11/20/25 when 37 controlled substance medications for 23 residents, held from 6/26/25-11/18/25, were destroyed with the CP and she did not sign the CDL as the destruction witness. The DON stated there was a risk for inaccurate controlled medication inventory, diversion of controlled medications and delayed identification of controlled medication diversion. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated 11/2022, the P&P indicated, .medications that cannot be returned to the dispensing pharmacy (e.g., non unit-dose medications, medications refused by the resident, and/or medications left by the residents upon discharge) are disposed of in accordance with federal, state and local regulations.individual resident medications supplied in sealed unopened containers may be returned to the issuing pharmacy for disposition provided that : the receiving pharmacist and a registered nurse employed by the facility sign a separate log.the medication disposition record contains, as a minimum, the following information.signature of witness. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to accurately label and store medications in one of two medication carts and one of two medication rooms when:1. Medication cart, referred to as, medication cart B, contained one prescription medication with no expiration date for one resident (Resident 30)2. Medication room, referred to as, medication room C, contained one expired prescription medication for one resident (Resident 6). This failure had the potential to decrease medication potency that could compromise the therapeutic effectiveness of stored medications.During a concurrent observation and interview on 12/2/25 at 2:29 p.m. with Licensed Vocational Nurse (LVN) 3, medication cart B was observed behind nursing station B. Resident 30's morphine sulfate (controlled substance medication used to treat pain) 15 milligram (mg-a unit of measurement) prescription medication was observed with no use by or expiration date on the pharmaceutical label. LVN 3 stated Resident 30 had not been administered morphine sulfate 15 mg since it had been ordered. LVN 3 stated she could not locate a use by or expiration date on Resident 30's morphine sulfate 15 mg prescription medication. LVN 3 stated all prescription medication from the pharmacy should be delivered with an expiration or use by date on the pharmaceutical label. LVN 3 stated when Resident 30's medication was delivered to the facility the receiving nurse should have identified the lack of a use by or expiration date and reported it to the pharmacy. LVN 3 stated it was important all medication had an expiration date or use by date label to ensure expired medication was not administered. LVN 3 stated if expired medication was administered it could lose its potency and not have the intended desired effect or cause adverse reactions. During a review of Resident 30's Order Summary (OSR), dated 12/4/25, the OSR indicated Resident 30 was ordered morphine sulfate oral tablet 15 mg every 2 hours as needed for pain on 10/17/25. 2. During a concurrent observation and interview on 12/2/25 at 3:30 p.m. with LVN 4, medication room C was observed locked behind nursing station C. Resident 6's triamcinolone acetonide injection kit 40 mg/ml (milliliters- a unit of measurement) was observed with an expiration date of 11/29/25. LVN 4 stated Resident 6's triamcinolone acetonide injection kit 40 mg/ml was expired and should not be in the medication refrigerator. LVN 4 stated night shift nurses perform medication room audits and remove discontinued and expired medications nightly. LVN 4 stated expired medication should not be in the medication room because there was a chance it could be administered. LVN 4 stated expired medication could cause adverse side effects or be less effective if administered. During a review of Resident 6's OSR, dated 12/4/25, the OSR indicated Resident 6 no longer had an active order for triamcinolone acetonide injection kit 40 mg/ml. The OSR indicated Resident 6's triamcinolone acetonide injection kit 40 mg/ml medication was discontinued on 6/4/25. During an interview on 12/5/25 at 11:44 a.m. with the Consultant Pharmacist (CP), the CP stated he performed monthly medication cart and medication room audits to assess and remove expired medications, discontinued medications and ensure medications were labeled accurately. The CP stated nursing was expected to review expiration dates before administration of medication and at routine intervals. The CP stated all prescription medications from the pharmacy were required to have an expiration date on the label before they were delivered to the facility. The CP stated nursing was expected to identify an incomplete pharmacy label on prescription medications when they were delivered and alert pharmacy for a replacement. The CP stated a complete and accurate pharmacy label was important to ensure expired medication was removed promptly and not administered. The CP stated there was a risk for administration if expired or discontinued medication remained in medication carts or medication rooms which could result in adverse side effects or decreased medication efficiency.During an interview on 12/5/25 at 2:13 p.m. with the Director of Nursing (DON), the DON stated she reviewed Resident 30's morphine sulfate 15 mg prescription medication and it did not have an expiration date on the pharmacy label.<br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The DON stated all medication from pharmacy required an expiration date before arriving at the facility. The DON stated the nurse who received Resident 30's medication was responsible to ensure the pharmacy label had an expiration date. The DON stated it was facility policy to ensure pharmaceutical medication labels were complete and accurate to ensure expired medication was not administered to residents. The DON stated facility policy was not followed when Resident 30's morphine sulfate 15 mg prescription medication did not have an expiration date on the label. The DON stated she reviewed Resident 6's triamcinolone acetonide injection kit 40 mg/ml prescription medication and it was expired. The DON stated Resident 6's medication was discontinued on 6/4/25 and should have been removed from the medication room refrigerator when it was discontinued, before it expired. The DON stated facility policy was not followed when Resident 6's triamcinolone acetonide injection kit 40 mg/ml prescription medication was left in the medication refrigerator after it was discontinued and after it expired. The DON stated it was important to remove improperly labeled prescription medication and expired medication to ensure expired medications were not administered to residents. The DON stated expired medications could become less effective and not work as intended or cause adverse side effects.During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, the P&P indicated, .the nursing staff is responsible for maintaining medications storage and preparation areas in a clean, safe, and sanitary manner.if the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.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 minimum: expiration date.if medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying the items. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview and record review the facility failed to ensure 19 of 49 residents receiving meals from the kitchen were served the correct serving for lunch on 12/3/25 when 19 residents on regular texture and portion diets were served sea greens with an incorrect serving size of #10 scoop (3/8 cup) instead of a #8 scoop (1/2 cup) serving. This failure resulted in 19 residents receiving the wrong caloric intake which could result in inadequate nutrition, weight gain or weight loss, and lead to serious medical conditions. During a review of the facility's document titled, Diet Type Report, dated 12/4/25, the document indicated 49 residents received meals from the kitchen. The document indicated 19 of 49 residents received regular texture diets with regular portions from the kitchen. During a review of the facility's recipe document titled, Sea Greens #2, undated, the document indicated, .suggested portion: #8.serve with a #8 scoop. During a concurrent observation and interview on 12/3/25 at 11:52 a.m. with Dietary [NAME] (DC) 1, in the kitchen during lunch tray line, DC 1 stated residents were being served meat and beans, potatoes, spinach (also known as sea greens), and cornbread for lunch. DC 1 was observed placing a #10 scoop on the tray line in the sea greens container. DC 1 was observed reviewing meal tickets and using a #10 scoop to serve sea greens onto the trays of residents with regular diet textures. DC 1 stated as the cook he reviewed recipes, made and served the food item per recipe during tray line. DC 1 stated he used sea greens #2 recipe to make and serve the sea greens. DC 1 stated serving scoop portion sizes were on each recipe and expected to be followed. DC 1 stated he was using a #10 scoop size to serve sea greens onto resident trays with regular diet textures and portions. During a concurrent observation and interview on 12/3/25 at 11:55 a.m. with DC 2, in the kitchen during lunch tray line, DC 2 was observed assisting DC 1 with tray line. DC 2 was observed reviewing meal tickets and using a #10 scoop size to serve sea greens onto the trays of residents with regular diet textures and portions. DC 2 stated he was using a #10 scoop size to serve sea greens onto resident trays with regular diet textures and portions. During a concurrent observation and interview on 12/3/25 at 12:09 with the Dietary Supervisor (DS), in the kitchen during lunch tray line, the DS stated residents were being served meat and beans, potatoes, spinach, and cornbread for lunch. The DS stated the Sea Greens #2 recipe was utilized for lunch. The DS stated the Sea Greens #2 recipe called for a #8 scoop size for serving. The DS stated DC 1 and DC 2 were using the incorrect serving scoop size, #10 scoop, to serve sea greens to residents on a regular texture diet with regular portions. The DS stated DC 1 and DC 2 should have used a #8 serving scoop size to serve sea greens to residents on a regular texture diet with regular portions. The DS stated DC 1 and DC 2 were responsible to prepare, make, and serve scheduled menu items per the recipe. The DS stated it was important to follow recipe guidelines to ensure residents received the correct nutrition ordered for their diet. The DS stated using the incorrect scoop size could lead to altered caloric intake, weight gain, weight loss, and altered nutrition.During an interview on 12/5/25 at 9:36 a.m. with the Registered Dietician (RD), the RD stated recipes were expected to be followed by dietary cooks when food items were prepared, made and served. The RD stated the DS was responsible to oversee the kitchen and ensure dietary cooks followed recipes and served correct portion sizes per diet orders. The RD stated it was important dietary cooks followed recipes and resident diet orders to ensure residents received the correct amount of nutrition to maintain their well-being. The RD stated the correct serving scoop size was important to ensure adequate nutrition was provided to each resident. The RD stated using the incorrect scoop size could lead to altered caloric, nutrient, vitamin and mineral intake which could result in weight gain, weight loss or altered nutrition. During an interview on 12/5/25 at 2:13 p.m. with the Director of Nursing (DON), the DON stated per facility policy she expected kitchen staff to follow recipes, menus and diet orders. The DON stated dietary cooks were responsible to ensure food items were prepared, made, and served per recipes, menus, and diet orders. The DON stated the DS and RD were responsible for ensuring kitchen<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | staff competencies. The DON stated facility policy was not followed when residents on a regular texture diet with regular portion sizes were served sea greens with a #10 scoop. The DON stated it was important to serve the correct portion size to ensure residents received adequate nutrition. The DON stated residents were at risk for weight variances, elevated or decreased blood sugar, and inaccurate nutrition monitoring when the incorrect serving scoop size was used to serve sea greens. During a review of the facility's document titled, Food Preparation, dated 2011, the document indicated, .portion control assures correct quantities are served to resident/patients to meet the nutritional specifications as determined by the menu. Standard portions are necessary to control food costs, quality, attractiveness and appeal of food. Resident/patient satisfaction is highest when expectations about the amount of food received are the same for all resident/patients.portions served are those listed on the menu for each food item.standard tools are utilized to assure portion control, i.e. scoops.standardized recipes.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 3/8 [cups] scoop size 10.amount in cups 1/2 [cups] scoop size 8.the dietary service supervisor (DSS) should routinely check portion control of all food/beverages. During a review of the facility's policy and procedure (P&P) titled, Menus, dated 10/2017, the P&P indicated, .menus meet the nutritional needs of residents in accordance with the recommend dietary allowances of the Food and Nutrition Board. menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal. |

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| | 555924 | A. Building<br>B. Wing | 12/05/2025 |

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| Bethel Lutheran Home | 2280 Dockery Avenue<br>Selma, CA 93662 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food and beverages were stored, distributed, and served safely in accordance with professional standards of food service safety for 49 out of 49 residents eating at the facility when: 1. Three packages of bread were expired in the dry good pantry.2. Two opened cereal containers were not labeled with received, opened and expiration dates in the dry good pantry.3. One opened crushed rosemary seasoning was expired in the kitchen preparation area.4. One lemon juice bottle was stored below meat and had a wet, yellow spotted sticky substance on the bottle in the serving preparation fridge.These failures had the potential to result in the serving of expired or contaminated food and beverage items which could result in foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins).1. 1. During a concurrent observation and interview on 12/2/25 at 10:17 a.m. with the Dietary Supervisor (DS), in the dry good pantry, three packages of bread were observed with an expiration date of 11/30/25. The DS stated the three packages of bread were expired and expected to have been removed from the dry good pantry on 11/30/25.2. During a concurrent observation and interview on 12/2/25 at 10:35 a.m. with the DS, in the dry good pantry, one opened cereal container was labeled with initials and a date of 10/24/25. The label did not indicate if 10/24/25 was a received, open or expiration date. The second opened cereal container was observed with initials and a date of 11/11/25. The label did not indicate if 11/11/25 was a received, open or expiration date. The DS stated when cereal bags were opened, it was transferred into a cereal container and labeled with a received (R ), opened (O), and expiration (EXP) date followed by the corresponding date. The DS stated the two opened cereal containers were not labeled correctly. The DS could not state if the dates on the two open cereal container labels were received, opened, or expiration dates. The DS stated all opened and transferred food items placed into containers required a R,O, EXP label with the corresponding date and staff initials. 3. During a concurrent observation and interview on 12/2/25 at 10:53 a.m. with the DS, in the kitchen preparation area, one opened bottle of crushed rosemary seasoning was observed with an expiration date of 8/15/24. The DS stated the crushed rosemary seasoning was expired and should not be in the kitchen preparation area for use. The DS stated every evening the night shift dietary cook was responsible to check food items in the kitchen for accurate labeling, dating and expiration. The DS stated she performed weekly audits to check food for accurate labeling, dating and expiration. The DS stated the Registered Dietician (RD) performed monthly audits to check food for accurate labeling, dating and expiration. The DS stated expired food items were not fresh and could affect the taste of food which could result in residents not eating or enjoying their meal. The DS stated expired food items could spoil and result in food borne illness or have decreased nutrition if consumed.4. During a concurrent observation and interview on 12/2/25 at 11:13 a.m. with DC 3, in the serving preparation fridge, a bottle of lemon juice was observed on the bottom shelf under turkey lunch meat and hot dogs. The bottle of lemon juice was observed with a wet, yellow spotted sticky substance on the top and sides of the bottle. DC 3 stated the bottle of lemon juice was expected to be clean, free from debris and residue. DC 3 stated the bottle of lemon juice should not have been placed under the turkey meat or hotdogs because it could leak on the lemon juice bottle and cause cross contamination. DC 3 stated the contamination could lead to food borne illness or illicit a food allergy if the lemon juice was served to a resident with allergies to the substance on the bottle.During an interview on 12/5/25 at 9:36 a.m. with the Registered Dietician (RD), the RD stated expired food items were to be removed from the kitchen on their expiration date. The RD stated all kitchen staff were responsible to identify and remove expired food items. The RD stated all food items were to be labeled with received, open and expiration dates to prevent expired food items from being stored or served. The RD stated there was a risk for expired food items being served to residents if they were left in the kitchen past their expiration date. The RD stated expired food items<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | could spoil, lose their taste, quality and nutrients. The RD stated it was important to remove expired food items from the kitchen to prevent food borne illness which could make residents sick. The RD stated all food items were expected to be stored clean and free from debris. The RD stated lemon juice was a ready to serve food item and should not be stored under food items like turkey meat or hotdogs that could potentially cross contaminate the juice served to residents. The RD stated cross contamination could cause food borne illness or illicit food allergies which could result in serios medical condition. During an interview on 12/5/25 at 2:13 p.m. with the Director of Nursing (DON), the DON stated expired food items were to be removed from the kitchen on their expiration date to prevent serving expired food items. The DON stated all food items in the kitchen were to be labeled with received, opened and expiration dates to prevent serving expired food items. The DON stated all food items were expected to be served in a safe and sanitary environment free from cross contamination. The DON stated facility policy had not been followed when three bags of expired bread were kept in the dry good pantry, two cereal containers were not properly labeled, one bottle of expired crushed rosemary was kept in the kitchen preparation area and one lemon juice bottle was stored under meats with an unknown substance on the bottle. The DON stated residents receiving food from the kitchen were at risk of foodborne illness and cross contamination which could result in serious medical condition.During a review of the facility's in -service titled, Labeling and Dating, dated 11/16/25, the in-service indicated it was important to label food items to prevent food spoilage, cross contamination and food illness. The in-service indicated if a food item was missing a label the food item was to be discarded. The in-service indicated a food label required product name, preparation date, use by date and initials.During a review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezers, dated 11/2022, the P&P indicated, . all food is appropriately dated to ensure proper rotation by expiration dates. Received dates (dates of delivery) are marked on cases and on individual items removed from cases for storage. Use by dates are completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food are observed and use by dates are indicated once food is open.supervisors are responsible for ensuring food items in pantry, refrigerators, and freezers are not past use by or expiration dates.refrigerators and freezers are kept clean, free of debris, and disinfected.During a review of the facility's P&P titled, Food Preparation and Service, undated, the P&P indicated, .cross contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. Cross- contamination can also occur when raw food touches or drips onto cooked or ready-to-eat foods.food preparation staff adhere to proper hand hygiene and sanitary practices to prevent the spread of foodborne illness.During a review of the facility's P&P titled, Food Receiving and Storage, dated 11/2022, the P&P indicated, .dry foods that are stored in bins are removed from original packaging, labeled and dated (use by date). Such foods are rotated using a first in-first out system .all foods stored in the refrigerator or freezer are covered, labeled and dated (use by date) .refrigerated foods are labeled, dated and monitored so they are used by their use-by date, frozen, or discarded . |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for one of 15 residents (Resident 9), when Resident 9's care plan indicated she needed one on one (1:1- one dedicated caregiver gives their full, undivided attention to just that person) supervision and a bolster (a long pillow or cushion) mattress on her bed and neither of those interventions were being implemented. This failure of not implementing an individualized care plan for Resident 9 had the potential to place Resident 9's safety at risk and her specific needs not being met.During a review of Resident 9's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the admission Record indicated, Resident 9 was admitted to the facility on [DATE] with a diagnosis of unspecified disorder of Alzheimer's disease (a progressive brain disorder that slowly destroys memory and thinking skills, eventually making it difficult to carry out simple daily tasks, and is the most common type of dementia, causing problems with memory, thinking, and behavior that worsen over time) muscle weakness, difficulty in walking and unspecified dementia (a general decline in mental abilities, primarily affecting memory, thinking, and behavior, that interferes with daily life and worsens over time).During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool used to identify resident cognitive and physical function) assessment, dated [DATE], the MDS assessment indicated Resident 9's Brief Interview for Mental Status (BIMS -assessment of cognitive(define) status for memory and judgment) assessment score was 00 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview). The BIMS assessment indicated Resident 9 was severely impaired. During a review of Resident 9's Care Plan Report (CPR), dated [DATE], the CPR indicated, .Resident is at risk for falls and/or repeated falls due to: Diagnosis: Alzheimer's, anxiety, dementia. difficulty in walking, generalized muscle weakness. history of falling. Goal: Minimize risks for fall and fall related. Date initiated: [DATE]. Interventions: . 1:1 supervision while awake. Date initiated: [DATE]. Bolster mattress. Date initiated: [DATE]. During an observation on [DATE] at 10:56 a.m., in Resident 9's room, Resident 9 was sitting in a wheelchair, awake, next to her bed without any staff present. Resident 9 had a hospital bed without bolsters or any other additions. During an interview on [DATE] at 1:39 p.m., with certified nursing assistant (CNA) 2, CNA 2 stated Resident 9 was not to be supervised with 1:1 care. CNA 2 stated if the care plan was not correct then ,staff could have given the wrong care for Resident 9. CNA 4 stated that care plans should be known by all staff and they tell staff, how to give care on a daily basis for the resident. During a concurrent observation and interview on [DATE] at 1:56 p.m., in Resident 9's room, with licensed vocational nurse (LVN) 1, Resident 9 was sitting next to her bed in a wheelchair and did not have 1:1 supervision by staff nor a bolster mattress on her bed. LVN 1 stated that she was Resident 9's nurse for the day. LVN 1 stated Resident 9 did not have 1:1 supervision by staff nor a bolster mattress on her bed. LVN 1 stated care plans were there to tell staff how to care for the resident on a daily basis. LVN 1 stated Resident 9's care plan was not individualized, comprehensive or person centered because she did not have 1:1 care nor a bolster mattress on her bed. LVN 1 stated the care plan was wrong and the care being provided was not accurate. LVN 1 stated Resident 9 was at risk for a fall because of the lack of a bolster mattress. During an interview on [DATE] at 2:40 p.m., with the Infection Preventionist (IP), the IP stated Resident 9's care plan was not person centered nor comprehensive. The IP stated the care plan needed to be updated to her individual needs and it was not. The IP stated care plans were important because they state what kind of care staff needs to provide the resident on a daily basis. The IP stated because the care plan was not accurate the<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident had the potential to get hurt because staff do not know what type of care the resident actually needs. During an interview on [DATE] at 3:17 p.m., with the Director of Nursing (DON), the DON stated the resident did need 1:1 staff support and bolsters on her bed at one point, but that was not the level of care she needed now. The DON stated Resident 9's care plan was not up-to-date, person centered nor comprehensive. The DON stated care plans are used by all staff to know what to do for the resident in order to keep them safe. The DON stated because the care plan was incorrect, Resident 9 could potentially get hurt because staff aren't doing the appropriate interventions for her current condition. The DON stated ultimately this was a patient safety issue. The DON stated staff did not follow the facility's policy and procedure Care Plans, Comprehensive Person-Centered. During a review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical. functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan: . reflects currently recognized standards of practice for problem areas and conditions. care plan interventions are chosen only after data gathering. careful consideration of the relationship between the resident's problem areas and their causes and relevant clinical decision making. assessments of residents are ongoing, and care plans are revised as information about the residents and the residents conditions change. During a review of Nursing World.org Professional Reference titled, The American Nurses Association- Nursing: Scope and Standards of Practice, Third Edition, dated [DATE], (found at https://www.nursingworld.org/~4af71a/globalassets/catalog/book-toc/nssp3e-sample-chapter.pdf) the reference indicated, .The Standards of Practice describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by registered nurses and forms the foundation of the nurse's decision-making. Standard 1. Assessment The registered nurse collects pertinent data and information relative to the healthcare consumer's health or the situation.During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated [DATE], (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of practice for one of thirteen sampled residents during medication administration (Resident 6) when Resident 6's Tylenol (pain medication used to treat mild pain) medication lacked an appropriate indication and an associated pain rating scale to guide administration.This failure resulted in Resident 6's Tylenol medication order not having complete and appropriate administration instructions which resulted in the administration of Tylenol with no prior pain assessment which could lead to uncontrolled or mismanaged pain management. During a review of Resident 6'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 12/4/25, the AR indicated Resident 6 was admitted to the facility on [DATE] with diagnoses of diverticulitis (an acute or chronic condition causing inflammation or infection of the large intestine lining), osteoarthritis (chronic condition causing breakdown of cartilage) and age-related osteoporosis (chronic condition causing breakdown of bone).During a review of Resident 6's Order Summary Report, (OSR) dated12/4/25, the Order Summary Report indicated, .Tylenol oral tablet 325 mg (milligram-a unit of measurement) give 2 tablet by mouth every 6 hours for mild pain.start date 6/8/25.During a medication pass observation on 12/4/25 at 11:04 a.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 was observed administering 2 tablets of Tylenol 325 mg to Resident 6. LVN 5 was not observed performing a pain assessment on Resident 6. Resident 6 was observed taking 2 tablets of Tylenol 325 mg.During a concurrent interview and record review on 12/4/25 at 2:28 p.m. with LVN 5, Resident 6's OSR, dated 12/4/25 was reviewed. LVN 5 stated Resident 6 had an active order for Tylenol 325 mg every 6 hours for mild pain. LVN 5 could not state if Resident 6 received Tylenol for acute or chronic pain from the order administration instructions. LVN 5 stated Resident 6's Tylenol administration instructions did not include an indication for use or an associated pain scale to guide administration. LVN 5 stated it was important administration instructions included the indication for use to ensure the medication was administered as prescribed by the provider. LVN 5 stated she did not complete a pain assessment prior to administration of Tylenol to confirm Resident 6 had mild pain. LVN 5 stated mild pain was a pain rating of 1-3. LVN 5 stated routine pain medication required a pain assessment prior to administration to ensure the appropriate medication was administered to appropriately treat a resident's level of pain. LVN 5 stated pain assessments tracked resident pain management progress and ensured pain management follow up occurred. LVN 5 stated Resident 6 was at risk for uncontrolled pain management with no pain assessment prior to administration, indication for pain medication use or associated pain scale.During an interview on 12/5/25 at 11:44 a.m. with the Consultant Pharmacist (CP), the CP stated administration instructions on all medications required indication for use. The CP stated licensed nursing staff were expected to complete pain assessments prior to pain medication administration. The CP stated licensed nursing staff were responsible for ensuring administration instructions were complete and to contact the provider if they were not. The CP stated pain assessments were important to ensure the proper pain medication was administered to treat the residents pain.During a concurrent interview and record review on 12/5/25 at 2:13 p.m. with the Director of Nursing (DON), Resident 6's OSR, dated 12/5/25 was reviewed. The DON stated Resident 6's order for Tylenol 325 mg every 6 hours for mild pain did not have an indication for use. The DON stated Resident 6's order for Tylenol 325 mg every 6 hours for mild pain should indicate the targeted condition, disease or rationale for use within the administration instructions. The DON stated it was important orders included indication for use to determine why and how long medication was intended for use to ensure appropriate monitoring was in place. The DON stated Resident 6's order for Tylenol 325 mg every 6 hours for mild pain did not have an associated pain scale to guide administration. The DON stated it was important orders included an<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | associated pain scale, such as a numeric pain rating scale, to ensure resident pain was assessed consistently and accurately by licensed nursing staff.The DON stated licensed nursing staff were expected to perform pain assessments prior to all scheduled, routine and as needed pain medication. The DON stated facility policy was not followed when Resident 6 did not receive a pain assessment prior to the administration of Tylenol. The DON stated facility policy was not followed when Resident 6 did not have an appropriate indication or an associated pain rating scale to guide administration on her Tylenol order. The DON stated Resident 6 was at risk for uncontrolled or mismanaged pain management, over-medication, under-medication or overdose when her medication, Tylenol 325 mg every 6 hours for mild pain, lacked an appropriate indication and an associated pain rating scale to guide administration.During a review of the facility's policy and procedure (P&P) titled, Medication and Treatment Orders, dated 7/2016, the P&P indicated, .orders for medications must include.clinical condition or symptoms for which the medication is prescribed.During a review of the facility's P&P titled, Pain Assessment and Management, dated 10/2022, the P&P indicated, .acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after the onset and reassessed as indicated until relief is obtained. For chronic stable pain the resident's pain and consequences of pain are assessed at least weekly.assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.if pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper analgesic medications to the extent possible.document the resident's reported level of pain with adequate detail (i.e., enough information to gauge the status of pain and the effectiveness of interventions for pain) as necessary and in accordance with the pain management program.During a review of the facility's P&P titled, Pain-Clinical Protocol, dated 10/2022, the P&P indicated, .the staff and physician will identify the characteristics of pain such as location, intensity, frequency, pattern and severity.staff will use a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level.if pain is stable and the underlying cause is resolved or it is unclear whether a source of pain remains, the physician will consider a trial reduction or elimination of analgesic medication .and see if there is any change in pain-related symptoms or use of PRN analgesics.based on results of attempted dose reductions, the physician should document a clinically significant rationale for not attempting further analgesic reduction. It should not just be assumed that the absence of pain symptoms implies the need for indefinite analgesic administration. Sometimes a trial tapering or discontinuation of analgesic is indicated to determine if current medications or doses are still needed.During a professional reference review retrieved from https://www.nccmerp.org/recommendations-enhance-accuracy-administration-medications titled, Recommendations to Enhance Accuracy of Administration of Medications, dated 3/30/23, the professional reference review from the National Coordinating Council for Medication Error Reporting and Prevention indicated, . one aspect of the overall medication use system, the following goals of the medication administration process should be included in the organizations processes and policies to ensure that systems are appropriately designed and functional for humans to safely administer medications.the right medication, in the right dose, to the right person, by the right route, using the right dosage form, at the right time, for the right reason. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>Based on interview and record review, the facility failed to ensure that medical records were complete for one of seven sampled residents (Resident 64) when Resident 64's Inventory of Personal Effects form (An Inventory sheet of resident's personal belongings completed upon admission to the facility) was incompletely filled out. This failure had the potential to result in Resident 64's poor continuity of care due to miscommunication among caregivers, inconsistent care delivery or loss or theft of personal belongings.During an interview on 12/4/25 at 11:29 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated an Inventory of Personal Effects form is filled out on admission by the CNA, signed by the CNA, and the form given to the nurse. CNA 1 stated the Inventory form should be filled out accurately and completely so that everyone knows what resident belongings were brought into the facility, resident items don't go missing, and to keep track of the resident's items. CNA 1 stated if the residents belongings were to go missing, it was important to have an accurately filled out inventory list so the responsible party (RP-the person designated in the admission agreement to manage the resident's affairs) and staff are aware of what items are missing.During a concurrent interview and record review on 12/4/25 at 3:09 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 64's Inventory of Personal Effects form, dated 11/19/25 was reviewed. The Inventory of Personal Effects form indicated, no documentation of resident or resident representative signature and date, witness signature, title of witness and date, Attending Physician name, Record Number, and Room/Bed. LVN 2 stated the Inventory of Personal Effects form was not complete and was missing several items of information such as attending physician name, resident room number, witness signature, and responsible party (RP) signature. LVN 2 stated Resident 64 had episodes of confusion and could not sign his own inventory form. LVN 2 stated Resident 64's RP should have signed the form. LVN 2 stated it was important to have all signatures on the Inventory of Personal Effects form because it ensured accuracy and that all personal items are accounted for. LVN 2 stated that an accurate form would provide staff with knowledge of what items were brought into the facility and would help in the event any items went missing or were misplaced. LVN2 stated when the form was not signed by the resident or the resident's RP, it could lead to miscommunication if items were lost. LVN 2 stated if a resident's form was not filled out completely and accurately and items were lost; there was a potential that items would not be verified. During a concurrent interview and record review on 12/4/25 at 4:02 p.m. with Medical Records (MR), Resident 64's Inventory of Personal Effects form, dated 11/19/25 was reviewed. MR stated she was responsible for auditing resident records the following day after a resident's admission. MR stated she checks that the Inventory of Personal Effects form has been completed by the CNA. MR stated she remembered giving the Inventory of Personal Effects form to the CNA on Resident 64's date of admission with only the resident's name written on it. MR stated she remembered it was a hectic day with two new admissions near the end of day, and she needed to clock out. MR stated the Inventory of Personal Effects form was not complete and was missing several items such as Physician name, medical record number, and RP signature. MR stated it was important to have accurate and complete Inventory of Personal Effects forms for the residents in case there were missing items, for reimbursement purposes, and for accuracy of items brought to the facility. MR stated she knew that it was important to have the medical record number on residents' paperwork because people could have the same name and the medical record number is specific to only one person and serves as the identifier for that resident. During a concurrent interview and record review on 12/5/25 at 2:26 p.m. with Director of Nursing (DON), Resident 64's Inventory of Personal Effects form, dated 11/19/25 was reviewed. DON stated Inventory Forms were completed by the CNA or Nurse on admission and as needed when items were brought in and out of the facility. DON stated her expectation was that medical records be complete and accurate with all information completed on the form. DON stated<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 555924 | A. Building<br>B. Wing | 12/05/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Bethel Lutheran Home | 2280 Dockery Avenue<br>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.

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|---|---|
| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | medical records was responsible for auditing the chart after an admission to check completion of forms. DON stated Resident 64's Inventory of Personal Effects form was not a complete form because there was no RP or resident signature, no physician name, no medical record number, and no room number. DON stated the form could have been signed by a witness if the resident was unable to sign. DON stated the medical record number was important in order to refer back to a resident. DON stated a patient could have the same name and the medical record is used to track each individual patient. DON stated it was important to have accurate and complete medical records and inventory forms to track resident belongings if items were to go missing. DON stated it was important for the RP to sign the inventory form to acknowledge the items that the resident came in with. DON stated her expectation was the inventory form be signed no later than 24-48 hours. DON stated the facility's policy states that medical records should be complete and accurate with all information on the form. DON stated that the facility's policy regarding complete and accurate medical records was not followed.During a review of Resident 64's admission Record, dated 12/5/25, the admission Record indicated Resident 64's admit date was 11/19/25.During a review of the facilities policy and procedure (P&P) titled, Charting and Documentation, dated July 2017, the P&P indicated, Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate . |

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| F 0947<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.<br><br>Based on interview and record review, the facility failed to have record of abuse in-service training for the year 2025 for one of three certified nursing assistants (CNA 4) reviewed. This failure had the potential to put all 49 residents at risk of experiencing abuse by staff. During a concurrent interview and record review on 12/4/25 at 10 a.m., with the Director of Staff Development/Infection Preventionist (DSD/IP) and Director of Nursing (DON), the abuse in-service training sign-in sheet (AIS) for employed certified nursing assistants (CNA) for 2025 was reviewed. The AIS indicated CNA 4 was not accounted for in having completed her abuse in-service for 2025. The DON stated CNA 4 was a full-time employee. During an interview on 12/5/25 at 2:51 p.m., with the DSD/IP she stated she was responsible for the abuse trainings but was not the DSD at the time of these trainings. The DSD/IP stated the expectation was that all CNA's received the required training, but CNA 4 was missing. The DSD/IP stated abuse training was important to educate staff on how to report and recognize abuse with residents at the facility. The DSD/IP stated missing these trainings would affect resident safety and staff might not know how to deal with abuse scenarios and care for them properly.During an interview 12/5/25 at 3:12 p.m., with the DON, the DON stated CNA's need to attend all of the required trainings and be proficient with the information they learned. The DON stated CNA 4 not getting the required abuse training would affect residents' quality of care negatively and it was a safety concern. The DON stated the facility's policy and procedure (P&P) In-Service Training, All Staff was not followed. During a review of the facility's Policy and Procedure (P&P) In-Service Training, All Staff, not dated, the P&P indicated, .All nurse aide personnel participate in regular in-service education. All personnel are required to participate in regular in-service education.Annual in-services: ensure the continuing competence of nurse aides. address the special needs of the residents. include training in . resident abuse prevention. all training supports current scope and standards of practice. required training for all staff include: . abuse, neglect and exploitation of residents. Nurse aid participation in training is documented by the staff development coordinator. and includes: the date and time of the training. B. The topic of the training; c. The method used for training; d. Summary of the competency assessment; e. The hours of training completed. |

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|---|---|
| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview during the survey period from 12/2/25 through 12/5/25, the facility failed to ensure each bedroom had 80 square feet of usable living space for residents in 22 of 29 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 to provide the residents in rooms 27, 28, 29, 31, 32, 33, 34, 35, 36, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59 and 60 with 80 square feet (sq ft- unit of measurement) of space had the potential for the residents to not have enough space to accommodate their personal needs and belongings. During an interview on 12/2/25 at 10 a.m., with the Administrator (ADM), the ADM stated he was aware rooms 27, 28, 29, 31, 32, 33, 34, 35, 36, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59 and 60 did not meet the minimum space requirement for two residents. The ADM provided the room measurements for rooms 27, 28, 29, 31, 32, 33, 34, 35, 36, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59 and 60. The room measurements were as follows: Room Number: Number of Beds/Residents: Square Footage per Resident:27 2 154 square feet (77 sq ft per resident)28 2 154 square feet (77 sq ft per resident)29 2 154 square feet (77 sq ft per resident)30 2 154 square feet (77 sq ft per resident)31 2 154 square feet (77 sq ft per resident)32 2 154 square feet (77 sq ft per resident)33 2 154 square feet (77 sq ft per resident)34 2 154 square feet (77 sq ft per resident)35 2 154 square feet (77 sq ft per resident)36 2 154 square feet (77 sq ft per resident)47 2 154 square feet (77 sq ft per resident)48 2 154 square feet (77 sq ft per resident)50 2 154 square feet (77 sq ft per resident)51 2 154 square feet (77 sq ft per resident)52 2 154 square feet (77 sq ft per resident)53 2 154 square feet (77 sq ft per resident)54 2 154 square feet (77 sq ft per resident)55 2 154 square feet (77 sq ft per resident)56 2 154 square feet (77 sq ft per resident)57 2 154 square feet (77 sq ft per resident)58 2 154 square feet (77 sq ft per resident)59 2 154 square feet (77 sq ft per resident)60 2 154 square feet (77 sq ft per resident) During an observation throughout the survey period from 12/2/25 through 12/5/25 twenty-two resident bedrooms (Rooms 27, 28, 29, 31, 32, 33, 34, 35, 36, 47, 48, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59 and 60) had two residents per room and had less than 80 square feet of space for each resident. Although the bedrooms accommodated less than 80 square feet for each resident, each room met the required needs of the residents. The residents had a reasonable amount of privacy, and closet and storage space was adequate. Bedside stands were available. There was sufficient room for nursing care and for the mobility of the residents. Wheelchairs, devices, and toilet facilities were accessible. The health and safety of the residents will not be adversely affected by the continuance of this waiver. Recommend waiver to continue in effect.<br>_____Beth [NAME], HFES Health Facilities Evaluator Supervisor Date 12/10/25 |